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Agenda

Meeting: Joint Public Health Board

Time: 10.00 am

Date: 19 November 2018

Venue: Committee Room 1, County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ

Bournemouth Borough Council	**Dorset County Council**	**Borough of Poole**
Nicola Greene Jane Kelly	Steve Butler Jill Haynes	John Challinor Karen Rampton
Reserve Members Blair Crawford	Rebecca Knox Andrew Parry	Mike White

Notes:

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- **Public Participation**

  Guidance on public participation at County Council meetings is available on request or at http://www.dorsetforyou.com/374629.

  Public Speaking

  Members of the public can ask questions and make statements at the meeting. The closing date for us to receive questions is 10.00am on 14 November 2018, and statements by midday the day before the meeting.

Debbie Ward
Chief Executive

Contact: David Northover, Senior Democratic Services Officer
County Hall, Dorchester, DT1 1XJ
01305 224175 d.n.r.northover@dorsetcc.gov.uk

Date of Publication:
Friday, 9 November 2018

Bournemouth, Poole and Dorset councils working together to improve and protect health

1. **Chairman**

To elect a Chairman for the meeting. (It was agreed at the previous meeting that the Chairmanship would rotate amongst the three authorities and that the Vice-Chairman identified at a meeting would become the Chairman at the following meeting).

2. **Vice-Chairman**

To appoint a Vice–Chairman for the meeting.

3. **Apologies**

To receive any apologies for absence.

4. **Code of Conduct**

Members are required to comply with the requirements of the Localism Act 2011 regarding discosable pecuniary interests and you should therefore:

- Check if there is an item of business on this agenda in which you or a relevant person has a disclosable pecuniary interest.
- Inform the Secretary of the Group in advance about your disclosable pecuniary interest and if necessary take advice.
- Check that you have notified your interest to your own Council's Monitoring Officer (in writing) and that it has been entered in your Council's Register (if not this must be done within 28 days.
- Disclose the interest at the meeting and in the absence of a dispensation to speak and/or vote, withdraw from any consideration of the item.

Each Council's Register of Interests is available on their individual websites.

5. **Minutes** 5 - 12

To confirm the minutes of the meeting held on 24 September 2018.

6. **Public Participation**

(a) Public speaking
(b) Petitions

7. **Forward Plan of Key Decisions** 13 - 16

To receive the Joint Public Health Board's Forward Plan.

8. **Public Health Dorset Business Plan 2018/19 - Monitoring Delivery** 17 - 30

To consider a report by the Acting Director of Public Health.

9. **Task and Finish Group on Future of Public Health Dorset : Findings and Recommendations from Stakeholders** 31 - 48

To consider a report by the Acting Director of Public Health.

10. **Community Health Improvement Services (CHIS) Procurement** 49 - 82

To consider a report by the Acting Director of Public Health.

11. **Health Improvement Services Performance Monitoring** 83 - 98

To consider a report by the Acting Director of Public Health.

12. **Financial Report** 99 - 104

To consider a joint report by the Chief Financial Officer and the Acting Director of Public Health.

13. **Questions from Councillors**

To answer any questions received in writing by the Chief Executive by not later than 10.00am on Wednesday 14 November 2018.

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Public Health Dorset

Joint Public Health Board

Minutes of the meeting held at the Civic Centre, Poole on Monday, 24 September 2018

Present:
Councillor John Challinor (Borough of Poole) (Chairman)
Councillor Jill Haynes (Dorset Country Council) (Vice-Chairman)
Councillors Karen Rampton (Borough of Poole), Jane Kelly (Bournemouth Borough Council) and Steve Butler (Dorset County Council).

Officers Attending: Nicky Cleave (Assistant Director of Public Health), Sam Crowe (Acting Director of Public Health), Sian Critchell (Finance Manager), Jane Horne (Consultant in Public Health, Public Health Dorset), Rachel Partridge (Assistant Director of Public Health) and David Northover (Senior Democratic Services Officer) and Clare White (Finance Manager).

(Note: These minutes have been prepared by officers as a record of the meeting and of any decisions reached. They are to be considered and confirmed at the next meeting of the Board to be held on **Monday, 19 November 2018**.)

Vice-Chairman
29 **Resolved**
That Councillor Jill Haynes be appointed as Vice-Chairman for the meeting.

Apologies
30 An apology for absence was received from Councillor Nicola Greene (Bournemouth Borough Council).

Code of Conduct
31 There were no declarations by members of any disclosable pecuniary interests under the Code of Conduct.

Chairman
32 **Resolved**
That Councillor John Challinor be elected Chairman for the meeting.

Minutes
33 The minutes of the meeting held on 4 June 2018 were confirmed and signed.

Public Participation
34 There were no public questions or public statements received at the meeting under Standing Orders 21(1) and (2) respectively.

Forward Plan of Key Decisions
35 The Joint Committee considered its draft Forward Plan which identified key decisions to be taken by the Joint Board, and items planned to be considered during the rest of 2018 and 2019. This had been published on 24 August 2018.

Noted

Public Health Dorset Business Plan 2018/19 - Monitoring Delivery
36 The Board considered a monitoring report by the Acting Director of Public Health on the delivery of the Public Health Dorset Business Plan for 2018/19, designed to assess progress against the Plan and what it was achieving. The report also highlighted national work underway to provide more publicly available information resources that could be used to compare local authority public health delivery.

The report set out a RAG rating for services and projects being provided by Public Health Dorset, which demonstrated to the Board what progress was being made towards achieving those deliverables.

The Board were satisfied with what progress was being made and understood where more attention was needed and the reasons for this. They considered the RAG rating to be helpful in their understanding of progress but asked that future charts indicated the direction of travel for each activity and action. Officers confirmed that it was the intention to provide information in future on outcomes in terms of what practical difference activities and intervention were making on the ground so that information on progress would be more meaningful. It was also agreed that information in respect of reference 1.4.1 and 1.4.3 be disaggregated into Bournemouth, Poole and Dorset.

Resolved
That the proposed approach to monitoring delivery of the Business Plan for 2018/19 be supported.

Reason for Decision
Close monitoring of the commissioned programmes was an essential requirement to ensure that services and resources were compliant and used efficiently and effectively.

Future of the Public Health Partnership: Update and Key Issues under Local Government Reorganisation

37 The Board received a report by the Acting Director of Public Health updating on key issues to consider as the public health partnership prepared for Local Government Reorganisation (LGR) in 2019. This included the work of the Task and Finish Group on the model of service, maintaining the contract and agreement in support of the partnership, and ensuring good governance on key decisions pre- and post- LGR. Members noted that they would receive an update at their meeting in November on the recommendations from the Task and Finish Group.

The proposal was to seek agreement - via the two Shadow Executive Committees of Dorset Council and Bournemouth, Christchurch and Poole Council - to extend the public health partnership for a minimum 24 months post- LGR, along with a continuation of the Board.

The Board considered what the current partnership model offered and how this might look following LGR so that how public health might be best delivered could be maintained. Of particular interest was how the contract would be designed and what length of time this should be; governance arrangements; and the future composition of the Board.

The Board considered that those recipients of GP referrals could access sports/leisure centres more readily so as to make use of what they offered.

The Board were pleased to know that Public Health England were satisfied with the arrangements the partnership had as it stood and the model that was being implemented and felt this would serve to stand them in good stead moving forward. The economies of scale associated with the model allowed for the opportunity for an improvement and enhancement of public health activities, but there was also a need to expand accessibility to other councillors about what the partnership did and how it operated. This could be better achieved by ensuring that any future report included reference to a public health impact assessment, which would draw attention to the integral part public health played in each and every service. Furthermore it was suggested that a seminar for both new Councils should be held on the work of Public Health Dorset and how it linked with the Health and Wellbeing Board, whilst

differentiating between the work of the two Boards.

Whilst it was being recommended that the current partnership arrangements should be maintained for a minimum of 24 months following LGR, the Board considered such a commitment was too prolonged should it be necessary for there to be an opportunity to deliver the public health agenda in an alternative way to suit what needs had to be met. Accordingly, the Board were more inclined to agree to a 12 months limit - to be reviewed thereafter - which would allow sufficient time for the partnership to continue to deliver its agenda in a practical, sustained and managed way, whilst subsequently providing that opportunity for arrangements to be adapted if necessary. On reflection, officers considered that 12 months was a reasonable compromise which would still achieve all that was necessary. Furthermore, this would still provide for the legal basis of the partnership - via the Shared Services Agreement - to be honoured and maintained.

Regarding the composition of Board from the options available, members considered that this could be determined over time whilst allowing for some flexibility in how the partnership continued to operate.

On that basis, the Board considered that support should be given to the way in which progress was being made, to take into account the provisions of LGR and that 12 months would be sufficient to provide for an extension to the partnership arrangements post LGR and - that following consideration by the constituent authorities Executive Committee's - the two Shadow Council's Executive Committees should be asked to endorse this approach.

Resolved
That progress made to date with establishing the future of the public health partnership under LGR be noted and supported.

Recommended
That the proposed arrangements for governance in the lead up to LGR and beyond be supported, with endorsement of a commitment being sought in advance of LGR - following consideration by the constituent authorities Executive Committee's - via the Shadow Executive Committees of Dorset Council and Bournemouth, Christchurch and Poole Council, to maintain the partnership for a minimum of 12 months following LGR in April 2019.

Reason for Recommendation
To maintain the partnership agreement for public health pre- and post- LGR, ensuring good governance and clear decision making as LGR progressed, and the continued effective delivery of the statutory legal public health duties of local authorities.

Financial Report

38 The Joint Board considered a joint report by the Chief Financial Officer and the Acting Director of Public Health on the draft revenue budget for Public Health Dorset in 2018/19, this being £28.592m, based on an indicative Grant Allocation of £33.407m.

The current revised budget was £28.142m, after a return of an anticipated £450k underspend. The Board's attention was drawn to an updated forecast for 2018/19, with a provisional budget for 2019/20 being shared, based on indicative figures published in 2017/18 and taking account of future local authority changes. Final grant figures would be published nationally in November/December 2018.

Resolved
That the change to 2018/19 budget and the reasons for this; the updated 2018/19 forecast; and the provisional budget allocation for 2019/20 all be noted.

Reason for Decision
Close monitoring of the budget position was an essential requirement to ensure that money and resources were used efficiently and effectively.

NHS Health Checks Service Model

39 The Board considered a report by the Acting Director of Public Health in providing an update on the development of a new model for delivery of the NHS Health Check Programme, and presented a proposed procurement approach. Officers explained that a new model was needed because the previous procurement process had resulted in many fewer people being invited to take part in the programme, which had adversely affected performance. This was largely due to the issue that contracts to offer the free check-ups were divided between pharmacies and GP partnerships across the county when these had been awarded in 2015. However, concern at the ability to successfully achieve all that was hoped had persisted in some areas - particularly those run by pharmacies - because they were unable to readily access patient's data. Consequently, the ability to provide the desired number of health checks had been compromised. The Board understood the need for this to be addressed and a practical means found for doing this.

Accordingly, the Board were informed of the background and rationale for change; updated on the mode of delivery and the recommended procurement model; and what was being recommended as a means to procure and award.

In acknowledging that the take up for health checks was markedly below what was expected or hoped, a new mechanism for improving this was being proposed, being based on the principles that:-

- the NHS Health Check Programme in Dorset needed to have the GP clinical record restored at the heart of the invitation and outcomes recording process;
- the NHS health check was not the end of the process, but rather an opportunity for lifestyle changes to be made;
- there should be plurality of providers to ensure patient choice.

A series of options for the delivery and procurement models had been explored and, based on the three principles agreed above, the procurement method proposed as the best option was - principally - that the contract for health check invitations should be directly awarded to those individual General Practices willing to participate, based upon one negotiated fee. It was considered that this approach would achieve the best results and outcomes. The timescale and budget implications for this were set out in the report too. Public Health Dorset and the Dorset Clinical Commissioning Group had assessed what needed to be done to improve the ability for health checks to be offered as anticipated.

The Board also acknowledged that for this service to be successful, the necessary processes should be complied with and followed in all cases. This in itself was seen to provide for a better understanding of what was being offered and what the take up was. In unifying the invitation for and undertaking of checks should markedly improve the results being seen. There was a need for the benefits of health checks to be better publicised and understood, in being seen not only as a preventive measure but as a means of identifying issues before them became critical. There was a case for these to be incentivised, if necessary, and targeted to ensure the greatest needs were met.

Once again there was a call for all Councillors to be better informed of what was being done, how it was being done and what benefits were being seen as a result of the checks to enhance their understanding.

The Board considered that on this basis it should be

Resolved
1.That the current unacceptable position in relation to delivery of health checks under the current tender arrangements, particularly the inequality in delivery across areas, be recognised and noted;
2.That the work being done to date to re-engage primary care with the Programme be acknowledged;
3.That the proposed health checks delivery model of directly awarding a contract for invitations to GPs, and to use a flexible framework for the delivery of health checks allowing different providers to join, be approved;
4.That the proposed budget for 2019/20 of £600,000 be agreed;
5.That the procurement and award of a new framework agreement for delivery of Health Checks be approved.

Recommended
That those resolutions be endorsed by the three constituent authorities Executive Committees, as necessary.

Reason for Decision/Recommendation
To enable service continuation and transformation through procurement.

Clinical Treatment Services Performance Report

40 The Board considered a report by the Acting Director of Public Health which provided a high-level summary of performance for drugs and alcohol and sexual health services, with supporting data set out in the appendices to the report.

The Board discussed the detail provided in respect of drugs and alcohol interventions and sexual health performance and what Public Health Dorset was doing to make improvements to these services to meet needs.

Members asked that they be provided with an age profile of those with alcohol dependency and their related illnesses so that they might have a more meaningful understanding of what might be done to address this and what categories might be better targeted.

The Board considered that although it was recognised that much work still needed to be done, the approach and action being taken on these issues remained satisfactory in addressing those issues and in making improvements towards desired outcomes.

Resolved
That the continuing interventions and actions being undertaken to address drugs and alcohol dependency and sexual health welfare be noted and endorsed.

Reason for Decision
Close monitoring of performance would ensure that clinical treatment services delivered what was expected of them and that the Public Health Dorset budget was used to best effect.

Questions from Councillors

41 No questions were asked by members under Standing order 20(2).

Exempt Business

42 **Resolved**
That under Section 100(A)(4) of the Local Government Act 1972 the public be excluded from the meeting for the business specified in minute 43 because it was likely that if members of the public were present there would be a disclosure to them of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A of the Act and the public interest in withholding the information outweighed the public interest in

disclosing that information.

Future Commissioning of Public Health Nursing (Health Visiting and School Nursing) - (Paragraph 3)

43 The Board considered a report by the Acting Director of Public Health on proposals for the future commissioning of Public Health Nursing - Health Visiting and School Nursing.

This was as a consequence of the Board approving a series of options for the future commissioning of this Service at their previous meeting on:-

- a competitive tender procurement;
- Pan Dorset model;
- 0-19 years integrated Public Health Nursing Service;
- Contract length;
- Maximum annual budget,

The Board discussed the options available, taking into account the procurement strategy development; Service requirements; the contract model; and the procurement process and what would be most beneficial to meet the needs of those using the Service. The new arrangements were designed to provide for a more robust and comprehensive service, more readily meeting the required needs. The Board agreed that this should take into account the balance between quality, price and performance so as to achieve all that was necessary. Further to this, members asked that an assessment of performance should be measured to ensure providers met the necessary specifications.

As an aside, the Board asked that alternative terminology should be arrived at to better describe this Service, to reflect what it had to offer.

Resolved

That the Market and Stakeholder consultation summaries and recommendations be noted and endorsed.

That the recommendations contained in paragraph 7.1 of the Acting Director's report as a basis to proceed with the procurement approach be supported and endorsed - with Proposal 2 of paragraph 7.1.1 being considered to be the best option - and that delegated authority for the Acting Director of Public Health - after consultation with the three constituent authority Portfolio Holders for Public Health - to award contracts to an appropriate provider following a successful tender and evaluation process, and on the best terms achievable, be agreed.

That the recommendation contained in paragraph 7.1.3 - for an agreement on proportionality - to be delegated to the Acting Director of Public Health to determine – but on the basis that 'quality' should be the defining, integral and fundamental factor in that decision.

Reasons for Decisions

Public Health Nursing services in Dorset were currently provided by Dorset Healthcare University NHS Foundation Trust. In order to comply with the necessary protocols and regulations, the new arrangements being proposed were seen to achieve this.

This procurement provided the opportunity to develop a pan-Dorset integrated 0–19 service specification for Public Health Nursing which imbedded the principles of Prevention at Scale within a Universal offer for children, young people and their families.

Meeting Duration: 10.00 am - 12.50 pm

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EXAMPLE PLAN - November 2018

FOR THE PERIOD 3 NOVEMBER 2018 TO 28 FEBRUARY 2019

Subject / Decision	Decision Maker	Decision Due Date	Consultation	Likely Exemption	Background documents	Member / Officer Contact
Future of Public Health - Task and Finish Group report	Joint Public Health Board	19 Nov 2018	Officers and portfolio holders from each member local authority. Internal discussions, separately and jointly.	Open	Board Report	*Sam Crowe, Acting Director of Public Health s.crowe@dorsetcc.gov.uk*
Finance Report	Joint Public Health Board	19 Nov 2018	Officers and portfolio holders from each member local authority. Internal discussions, separately and jointly.	Open	Board Report	*Sam Crowe, Acting Director of Public Health s.crowe@dorsetcc.gov.uk*
Health Improvement Services Performance Monitoring	Joint Public Health Board	19 Nov 2018	Portfolio lead for Integrated Community and Primary Care Services,	Open	Board Report	*Sam Crowe, Acting Director of Public Health s.crowe@dorsetcc.gov.uk*
Community Health Improvement Services (CHIS) Procurement	Joint Public Health Board	19 Nov 2018	Portfolio leads for One Acute Network.	Open		*Sam Crowe, Acting Director of Public Health s.crowe@dorsetcc.gov.uk*

Subject / Decision	Decision Maker	Decision Due Date	Consultation	Likely Exemption	Background documents	Member / Officer Contact
Business Plan Monitoring	Joint Public Health Board	19 Nov 2018			Business Plan Monitoring	*Sam Crowe, Acting Director of Public Health s.crowe@dorsetcc.gov.uk*
Finance Report	Joint Public Health Board	4 Feb 2019	Officers and portfolio holders from each member local authority. Internal discussions, separately and jointly.	Open	Board Report	*Sam Crowe, Acting Director of Public Health s.crowe@dorsetcc.gov.uk*
Clinical Services Performance Monitoring	Joint Public Health Board	4 Feb 2019			Clinical Services Performance Monitoring	Jill Haynes, Deputy Leader and Cabinet Member for Health and Care *Sam Crowe, Acting Director of Public Health s.crowe@dorsetcc.gov.uk*
Children's Public Health Nursing Procurement Update	Joint Public Health Board	4 Feb 2019	Portfolio leads for Digitally Enabled Dorset, and Leading and Working Differently.	Open		*Sam Crowe, Acting Director of Public Health s.crowe@dorsetcc.gov.uk*
Future of Public Health	Joint Public Health Board	4 Feb 2019			Future of Public Health	*Sam Crowe, Acting Director of Public Health s.crowe@dorsetcc.gov.uk*

Subject / Decision	**Decision Maker**	**Decision Due Date**	**Consultation**	**Likely Exemption**	**Background documents**	**Member / Officer Contact**
Business Plan Monitoring	Joint Public Health Board	4 Feb 2019			Business Plan Monitoring	*Sam Crowe, Acting Director of Public Health s.crowe@dorsetcc.gov.uk*

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Joint Public Health Board

Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	19 November 2018
Officer	Acting Director of Public Health
Subject of Report	**Public Health Dorset Business Plan 2018/19 – monitoring delivery**
Executive Summary	The Board received the Public Health Dorset monitoring report, based on the Business Plan for 2018/19, at its September meeting. Members endorsed the approach and commented that it would be useful to include trend data within the report. The monitoring report has been updated to incorporate Member feedback and updates on performance for Quarter 2. The report also highlights national work underway to provide more publicly available information resources that can be used to compare local authority public health delivery.
Impact Assessment:	Equalities Impact Assessment: A separate equality impact assessment is not carried out for the business plan. However, where activity in the business plan affects service delivery, such as via commissioning and contracting decisions, equalities impact assessments are carried out in line with policy.
	Use of Evidence: The business plan is a summary of the Public Health team's planned activity for 2018/19. A range of evidence is used to inform how we plan to work, including national guidance and standards for delivery of public health services.
	Budget: The Business Plan identifies how we will spend the 2018/19 budget of £28.6m. When used alongside national benchmarking and performance information, it provides a more complete picture of whether local commissioning and provision of public health services is providing value and improving outcomes.

	Risk Assessment: Having considered the risks associated with this Business Plan using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk LOW As in all authorities, performance continues to be monitored against a backdrop of reducing funding and continuing austerity.
	Other Implications: None.
Recommendation	The Board is asked to note the performance update of the 2018/19 Business Plan.
Reason for Recommendation	Close monitoring of the commissioned programmes is essential requirement to ensure that services and resources are compliant used efficiently and effectively.
Appendices	PHD Business Plan monitoring report, 2018/19.
Background Papers	Various including current Prevention at Scale Plans, commissioning and project plans associated with the delivery of team business,
Report Originator and Contact	Name: Sam Crowe, Acting Director of Public Health Tel: 01305-225884 Email: s.crowe@dorsetcc.gov.uk

1. Background

1.1 The Joint Public Health Board exists to provide oversight, assurance and governance around the effectiveness of the delivery of the public health function for the Upper Tier authorities of Dorset, Bournemouth and Poole.

1.2 An important part of this role is understanding how the Public Health Grant allocation is used to commission effective public health services, and whether those services are providing value for money, when judged against local priorities for improvement in health and wellbeing and reducing inequalities in health.

1.3 Nationally, the direction of travel is for increasing transparency and accountability for the effectiveness of local authority public health delivery. Partly this is in response to questions over how the ring-fenced Public Health Grant has been used in some authorities, not least Northamptonshire, which has had severe financial challenges. There is also interest in increasing understanding of how the Grant is being used, and the effectiveness of local authority public health delivery, as part of preparations for considering removing the ringfence beyond 2020.

1.4 Earlier this year Public Health England wrote to all Local Authority chief executives to formally launch a new publicly available tool, Healthier Lives. This has been developed to increase the transparency of local authority public health data. It allows for a number of public health measures to be compared across local authorities within the CIPFA nearest neighbour group, producing a summary ranking. The domains for which data is available are: Childhood Obesity, Air Quality, Drugs and Alcohol treatment, Best start in Life, NHS Health Checks, tobacco control, and sexual and reproductive health. The tool can be accessed at https://healthierlives.phe.org.uk/.

1.5 Public Health Dorset has produced a business plan for the past three years, with the aim of increasing visibility of commissioning and service provision plans. For this financial year, we have developed the plan further, recognising that the way in which we are delivering additional work under the Prevention at Scale plans would benefit from clearer milestones and deliverables, particularly to increase partner understanding in the Joint Public Health Board and beyond.

1.6 At the June Board Members had a chance to look at the business plan in detail. While broadly supportive, Members did comment that it would be helpful to see a clearer delivery plan to enable monitoring of delivery.

1.7 The delivery plan was presented at the September Board and Members noted that it would be helpful to include trend data. Appendix 1 sets out our updated approach to monitoring the delivery of the business plan based on Member feedback.

2. Current position

2.1 The monitoring plan shows that most deliverables are on track to achieve their milestones in 2018/19. The approach to RAG rating has been to consider progress in delivery, not effectiveness or outcomes.

2.2 There are three areas currently red rated. This includes the NHS Health Checks programme, because of the degree of drop off in delivery of invitations and checks, and the current continuing risk around not being able to invite people to the programme. Engagement of people with drug and alcohol issues with treatment services is also red rated currently – this is an area where several measures around access to treatment and drug related deaths are judged to be poor when compared

with similar authorities. The recent data on drug related deaths for two areas covered by Public Health Dorset is also a concern (Weymouth and Portland, and Bournemouth). The third area is the Escape Pain project, which has now been revised and will be taken forward working closely with musculo-skeletal services as part of routine care. It has taken considerable time to gain agreement on this approach, working with acute sector colleagues.

3. Next steps

3.1 This summary paper and the associated monitoring report is focusing on progress against deliverables, rather than outcomes. However, we are committed to sharing with the Board more information on outcomes for our major commissioned programmes to improve transparency and accountability. The paper on this month's agenda is on health improvement services, and public health nursing indicators.

4. Recommendations

4.1 The Board is invited to comment on and endorse the proposed approach to monitoring delivery of the Business Plan for 2018/19.

4.2 In addition, Board members are asked to note the quarter 2 performance update against the 2018/19 business plan.

Sam Crowe
Acting Director of Public Health
19 November

Public Health

2018/19 Business Plan Monitoring Report

Bournemouth, Poole and Dorset councils
working together to improve and protect health

Public Health Dorset

Contact:	Sam Crowe, Acting Director of Public Health
Year:	April 2018 - March 2019
JPHB meeting date:	November 2018

RAG Status

- Red - Serious challenge, remedial action required, out of tolerance
- Amber - Some challenges, mitigating action in place, within tolerance
- Green - On target
- Blue - Complete
- Black - Cancelled
- White - Not started

Trend Status

- ↓ Decrease in performance
- → No change in performance
- ↑ Increase in performance

Reference	Key activity/action	Performance Measure and Target	Senior Responsible Officer	Previous RAG Status	Current RAG Status and Trend	Progress Update	Annual Activity/Action Outcome
1. Prevention at Scale Projects							
1.1. Starting Well							
1.1.1	Embed behaviour change and lifestyle support through LWD digital in maternity care pathways	Number of referrals made from maternity to LiveWell Dorset or LiveWell Dorset digital.	Jo Wilson		→	The LiveWell Dorset digital offer will be a part of the maternity single point of access website. Training for midwives around motivational interviewing. A SoP has been agreen between Midwives and Health Visitors and includes behaviour change.	
1.1.2	Ensure an effective, single 0-5yrs offer through combining Children Centre and Health Visiting Pathways	Reduction in referrals to speech therapy and increase in school readiness. More early interventions.	Jo Wilson (Partner Led)		→	The 0-5 pathway launched on the 26 September with health visitors and childrens centres. There is a SALT task and finish group established and is developing a business case which will be presented to the CCG in December/January.	
1.1.3	Engage schools and build whole school approaches to health and wellbeing	Increase in activity levels in children and young people. Number of schools engaged, activities delivered and children involved.	Jo Wilson		↑	Plans to increase physical activity developed in schools supported by work with the Head Teacher's Alliance were launched in September. The deadline for applications is the 5 November.	
1.1.4	Build community capacity through training to support children and young people to THRIVE	Number of children and young people workforce trained in MHFA (Mental health first aid) Impact statements from workforce of how training has been used.	Jo Wilson		↑	Not chosen to become a national Trailblazer for Emotional and Mental Health and Wellbeing around schools building on local developments to date. Public Health Dorset are leading a task and finish group on counselling services for children and young people. The task and finish group recently met and are taking a paper to the Early Health and Wellbeing Strategy Group in November with recommendations for the scope of work. Roll out of MHFA continues.	
1.2 Living Well							

1.2.1	Development and Launch of LiveWell Dorset digital	10000 people accessing behaviour change support per year.	Stuart Burley		→	The LiveWell Dorset digital platform is fully live, including the MyLiveWell registration section. There has been a surge in connections with LiveWell Dorset following the launch of the digital platform. The site is receiving an average of 3000 people per month.	
1.2.2	Market LiveWell Dorset to GPs	GP's engaged, trained and using LiveWell	Stuart Burley		→	All GP practices have tailored communications and data on service utilisation which is currently being disseminated as part of a marketing plan.	
1.2.3	Health checks incentivisation with GP's	Number of Health Checks being performed. Number of referrals to LWD as a result of a Health Check.	Sophia Callaghan		↑	Following the paper in September, 2,111 health checks were carried out in Quarter 1 of 2018/19. Work is underway with LiveWell Dorset to improve referrals and monitoring following a Health Check. New Health Check awareness letters are in draft and include LiveWell Dorset information.	
1.2.4	Develop and implement co-ordinated staff health and wellbeing plans within the health and care system.	Engagement of organisations and 7 plans developed. Some delivery within plans e.g. % staff groups attending training. Percentage who have had Mental Health First Aid training. Number of training courses. What people have done with the training they have received?	Sophia Callaghan		↑	Workshop offer in place for all main organisations (LAs, hospitals and Dorset Healthcare) for skills development for staff. A link to the LiveWell Dorset digital website on the intranet of all organisations. LiveWell Dorset healthy conversations/referral process is embedded in the curriculum for preceptorship, new recruits, overseas for main providers. MEC ran in September/October, 24 set up as train the trainer and the aim is to develop a sustainable offer/network across the system. 7 workshops have been held with DCH which 70 people attended - an insights report is due to go back to their board and RBH have expressed an interest.	
1.3. Ageing Well							

1.3.1	To develop and implement a plan to promote Active Ageing	Increase in 55-65 year olds registering with LiveWell on a Physical Activity pathway.	Rachel Partridge		↑	Scoping of system changes for all three pathways (primary and secondary care, workplaces, schools) has been completed, key contacts for each have been identified and meetings held with project/pathway leads to discuss system changes and timescales. Significant early progress has been made in both cancer and diabetes pathways with system changes identified and work underway to implement these	
1.3.2	Transform diabetes pathways through linking with prevention activities in Dorset.	Number of referral to National Diabetes Prevention Programme (NDPP). Anecdotal/story e.g. what has happened in a locality or how connected into LWD.	Jane Horne		↑	7 of the 12 localities have launched the National Diabetes Prevention Programme and the remaining 5 will do so by the end of January.	
1.3.3	Escape pain	N/A	Vicki Fearne			Delays and issues with implementation. A revised options paper is due to go to September MSK task and finish group with a recommendation that this is incorporated within the physiotherapy review.	
1.3.4	Collaborative Practice	Successful procurement with an effective service mobilised.	Susan McAdie		→	14 GP practices engaged and recruiting practice health champions across 10 localities. A second year delivery plan will be available end of December 2018.	
1.4. Healthy Places							
1.4.1	Build capacity to address inequalities in access to greenspace	The database will allow us to understand a) the distribution of physical accessibility to greenspace across Dorset b) how this is related to population health c) secure a tool to engage our partners in increasing access to greenspace at scale. A roadmap produced with measures to enhance greenspace access at scale.	Rachel Partridge		→	Pan Dorset accessible greenspace database and walkable network created in partnership with University of Exeter to identify inequalities in physical access to greenspace. Greenspace accessibility enhancement projects underway with Local Authority Partners. A stakeholder workshop was held in October 2018 to identify system wide intelligence needs for enhancing access to greenspace at scale. The learning from the workshop is currently being collated.	

1.4.2	Embed planning for health and wellbeing across spatial planning system	Strengthen connections between health and planning systems and identify priorities for future collaboration. Local planning policy influenced (and its implementation) to promote population health and wellbeing.	Rachel Partridge		→	Key points of contact and consultation routes identified with all LPAs. A joint workshop between officers from PHD, CCG and LPAs identified measures for improving system wide engagement. Proposed process for involvement of PHD staff in ongoing engagement with planning and supporting guidance developed in conjunction with LPAs and PHE.	
1.4.3	Improve poor quality housing (Healthy Homes Dorset)	Number of clients (which includes those accessing "soft" measures: advice, referrals to other services, income maximisation, etc). Number of heating/insulation measures installed.	Rachel Partridge		→	To date the Healthy Homes Dorset programme has the following: 949 clients 1509 enquiries 210 meausures across Dorset, Bournemouth and Poole. Phase 2 questionnaires are currently being collated and are due to be processed in December.	
1.4.4	Installation of a Pan Dorset air quality network	To build an evidence base of the levels and sources of particulates that impact on air quality across Dorset to influence action to improve air quality.	Rachel Partridge		→	Six air quality monitors (monitoring particulate concentration) have been installed forming the foundation of the network providing a live data feed: https://public.tableau.com/profile/public.health.dorset#!/vizhome/AirMonitorData/APStory Discussion with EHOs is ongoing to agree deployment of filter monitors (enabling speciation of particulates) and enhancement of network coverage (gaps remain in Mid and North Dorset). National (Defra, PHE) and local (local authorities) stakeholder engagement underway to inform delivery of air quality intelligence. The Pan Dorset air quality network was presented at the PHE conference in September.	
1.5. Locality Working							
1.5.1	Link with key stakeholders in the locality. Use data to support planning. Highlight links with existing initiatives in other areas. Embed prevention actions in Local Transformation Plans. Evaluate progress with a focus on scale. Communicate success and learning across stakeholders and wider system.	Outputs are communicated across the system. PAS is included in local transformation plan. Examples of key projects as a result of links made by locality link workers.	Chris Ricketts		→	PHD now have a full complement of staff nominated to work in the thirteen localities for up to two days a week. Moving forward to the autumn, the plan is to engage localities in discussing the next steps for some key public health services: smoking cessation, NHS Health Checks and contraception.	

2. Commissioning and Services							
2.1. Procurement							
2.1.1	Children and Young People 0-19 years universal services development	To successfully award a compliant provider for a 0-19 Public Health Nursing service	Jo Wilson		→	Service specification has been developed with partners. Tender pack has also been developed.	
2.1.2	Health Checks Service including invitations	A successful procurement resulting in a collaborative approach to Health Checks across localities. Plans mobilised by locality workers.	Sophia Callaghan		↑	The Board signed-off the proposal to direct award invitations to individual general practices based upon a negotiated fee agreed with the LMC. PHD have developed a comms plan for engagement. Letters and specifications have been agreed in draft. The next stage will be a framework agreement under any qualified provider for April 2019 and procurement will start in November to January subject to approval.	
2.1.3	Smokestop Service	To successfully award a compliant provider(s)	Stuart Burley		→	Smoking cessation services will procure a Flexible Framework Agreement of qualified providers (e.g. GP's and Pharmacies) in order to direct award contracts for smoking cessation from April 2019.	
2.1.4	Emergency Hormonal Contraception (EHC) and Long Acting Reversible Contraception (LARC) Services	Services successfully integrated into the SH service or a successful procurement	Sophia Callaghan		→	A review of LARC has taken place by PHD and Dorset Healthcare (DHC). Due to in-year cost pressures, the decision has been made to keep EHC and LARC contracts for 2019-20 with a view to integrating these into the sexual health tender in 2019-20.If DHC decide to shadow for one-year, while GP engagement takes place PHD will procure a Flexible Framework Agreement of qualified providers (e.g. GP's and Pharmacies) to direct award contracts for emergency hormone contraception (EHC) from April 2019.	
2.1.5	Weight Management Service	To successfully award compliant provider (s)	Stuart Burley		→	The weight management programme, which is part of the LiveWell Dorset support for the healthy weight pathway will tender for 2019/20. Commissioning and procurement commence in September for a new service.	

2.1.6	Needle Exchange Service	To successfully award compliant provider (s)	Will Haydock		→	The DPS model used for this contract ends in March 2019 and replacement procedures are being set up by the team. It has been proposed to procure a Flexible Framework Agreement of qualified providers (e.g. GP's and Pharmacies) in order to award contracts for needle exchange from April 2019.	
2.1.7	Supervised Consumption Service	To successfully award compliant provider (s)	Will Haydock		→	The DPS model used for this contract ends in March 2019 and replacement procedures are being set up by the team. It has been proposed to procure a Flexible Framework Agreement of qualified providers (e.g. GP's and Pharmacies) in order to award contracts for needle exchange from April 2019.	
2.1.8	Flu Immunisations	To successfully award compliant provider (s)	Rachel Partridge			In discussion with Public Health England and NHS England to work out which scemes will be available for front line staff for the 2018/19 flu season.	
2.1.9	Residential Detox and Residential Rehabilitation Service	To successfully award a compliant provider (s) and a new service in place.	Will Haydock		→	New contracts in place from the 1 October 2018 and will run for 12 months. In this period and in light of LGR we will review whether arrangements are appropriate and meet local need.	
2.1.10	Refresh Halo system	To have a compliant provider in place.	Will Haydock		→	Existing arrangements with Footwork Solutions have been extended to March 2020. In this period and in light of LGR we will review in partnership with other health and social care providers whether alternative more integrated solutions are appropriate.	
2.1.11	Drugs and Alcohol service user organisations	To have a grant in place.	Will Haydock		→	A grant agreement is in place.	
2.2. Contract Management and Services							

2.2.1	Delivery of an evidence based behaviour change service - LiveWell Dorset - to increase the scale, reach and impact of behaviour change and health improvement support.	10,000 referrals to LWD per year 5,000 referrals from primary care per year Minimum of 25% accessing support from deprived areas Minimum of 500 key workforce employees supported with behaviour change training per year Numbers supported i.e. sustained change	Stuart Burley		→	LiveWell Dorset is increasing its scale, reach and impact of behaviour change support and most KPIs are on trajectory to being achieved.	
2.2.2	Dorset Integrated Substance Misuse Services, Prescribing and Psychosocial support	Improving engagement rates in Bournemouth (more reach – more people in treatment services) and maintaining performance (successful completion rates) in Dorset and Poole	Will Haydock		→	A review of the engagement and treatment of opiate users in Bournemouth is ongoing. Current rates of drug related deaths are unacceptable and likely to be linked to low levels of engagement and historic prescribing practices which do not appear to be in line with national guidance.	
2.2.3	Health Visiting and School Nursing	Number and percentage of mandatory checks completed Numbers of children supported through Universal, Universal plus and Universal Partnership Plus. Number of children contacting CHAT Health. To complete the 0 – 5 integrated pathways with Children's Centres To embed the SN model including contributing to School Leadership and Digital applications.	Jo Wilson		↑	Health visitor performance maintained above South West averages. Looking to scale CHAT health and digital approaches will be key to the procurement of the new service. Integrated pathways from September. SN profile work underway. SN podcasts are part of a national project and recently won Best Podcast at the ARIAS 2018 awards.	
2.2.4	Breast Feeding Support Delivery	Increase in the number of peer supporters. Increase in the number of support groups in areas of low rates. Increase in the numbers attending support groups. Increase in number of women who breastfeed until 6-8 weeks.	Jo Wilson		→	Breastfeeding support delivered by FAB through the Public Health grant. Agreed to develop a sustainability plan with the and a one year grant is in place to support. There is planned consultation with service users.	

2.2.5	Integrated Sexual Health Service	An effective integrated service working collaboratively across the system. Increase in partner notification. Increase in confidence around sexual health. Increase Chlamydia positive results. Reduce attendance of frequent flyers. Increase new attendances. GP/Pharmacy model re-design.	Sophia Callaghan		→	Significant progress in joint work and relationship building across providers over the last year with system wide agreements at executive level and change is developing at pace.. A single phone line and more interactive website is in place, with better support, information and easy access to services, on line testing is being improved and training programmes are running to ensure a quality skill mix for staff. The outreach model is much stronger and more flexible in approach. A hub and spoke model with improved triage has streamlined services to manage capacity of both staff and clinics more effectively and ensures that the needs of patients are met first time, and are efficient with people seeing the right professional first time. Chlamydia figures show that total numbers screened locally are higher than England average with diagnoses for under 25s decreasing and over 25s increasing. Contract management plans are in place to monitor and progress service.	
2.2.6	Smoking Cessation and midwifery pathway in Bournemouth, Poole and Dorset	Number and Percentages of Pregnant women who smoke that have been supported by the service and quit at 4 weeks.	Jo Wilson		→	Commissioning intentions to be explored for 2019/20 to mainstream behaviour change in Midwifery. Most recent contract meeting data shows that 52% quit at 4 weeks.	
2.2.7	Health Checks Invitations	Percentage of invites sent out to eligible individuals.	Sophia Callaghan		→	Quarter 2 data is currently being processed.	
2.2.8	Commuity Health Improvement Services (Health Checks, Smoke Stop, EHC, LARC, Needle Exchange, Supervised Consumption, Weight Management)	Numbers accessing and receiving the services. Numbers successfully quit smoking.	Sophia Callaghan		→	Quarter 2 data is currently being processed.	

2.2.9	Collaborative Practice	Number of practices engaged across B, P and D and participated in leadership programme. Number of practice champions. Number of activities set up.	Susan McAdie		→	The Collaborative Practice development programme is on track to finish in November, and most practices have agreed their timetable for Practice Champion recruitment and follow up workshops. 77 practice champions have been recruited to date and two practices have recruited 14 and 16 champions who are focusing on physical activity, healthy eating, diabetes support and isolation. So far, 53,005 patients have been invited to become involved, 2,184 (4%) of these had positively responded, 351 (16%) had completed formal application forms, 153 have been invited to attend practice workshops and 105 have attended these workshops.	
2.2.10	Residential Detoxification with 24/7 nursing cover	Number of service users supported.	Will Haydock		→	See 2.1.9	
2.2.11	Cardiff Model	Improved data collection. Actions implemented to reduce alcohol/drug related violence admissions.	Rachel Partridge		→	This project is ongoing and working with three acute trusts. The data quality is good and the next step is engaging with stakeholders on the next steps and how to use this data.	
3. Enabling Services and Support Projects							
3.1	To plan, deliver and continually improve the internal and external communications function	INTERNAL - The Wall is being used across the team. Team meetings revised and team engaged. EXTERNAL - Increased hits to PHD website. Communications team in post. Partners better informed. PAS key messages developed and communicated. Branding developed and PAS presence improved on social media.	Chris Ricketts		↑	Good progress with full communications team now in post. Our team intranet is being well used, but we at the same time reviewing it to see whether we are able to introduce additional functionality. Continued development of PHD website and PaS material for the Our Dorset website. Improved use of social media.	
3.2	To plan, deliver and continually improve the Business Support Function	Business support roles reviewed. Business support develop a project support role within Sycle and Project Place. Business as usual activities, such as team/staff requests, communication, HR and recruitment and finance are undertaken	Barbara O'Reilly		→	Business support roles have recently been reviewed and members of the team have been aligned to support prevention at scale workstreams and business as usual activities.	

	3.3 To plan, deliver and continually improve the Contracts and Commissioning Function	Clarity of TOR and purpose of the contracts and commissioning group. Procurement project teams are supported. Contracts are managed effectively through an annual business cycle.	Sophia Callaghan		→	The Contracts and Commissioning Group governs the contracts and commissioning intentions and reports to Public Health Dorset's Senior Management Team which then reports to the Joint Public Health Board. New system in place with level three contracts (managed by leads) and level four (managed as business as usual).	
	3.4 To plan, deliver and continually improve the Organisational Development Function through: 1) Aligning individual performance with business and development planning 2) Building leadership and capability 3) Recruiting and retaining high quality staff and maximise staff engagement 4) Supporting cultural change and transformation	Strategic and resource planning. Staff have an annual work plan where objectives are linked to business plan. CPD offer developed and valued. Staff engaged in team meetings and away days. Staff survey conducted with continual improvements based on results. H&WB strategy developed and implemented. Staff informed and consulted through change.	Amy Lloyd		→	PHD Business, delivery and resourcing plan developed and framework in place to continually monitor and update through the year. Staff resourcing to feed into midyear reviews to ensure staff objectives linked to the business plan are fed into PDR's. CPD offer and handbook in development. Staff survey administered and results currently being interpreted to inform our current organisational situation, staff engagement, communication, health and wellbeing and training.	

Public Health Dorset

Joint Public Health Board

Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	19 November 2018
Officer	Acting Director of Public Health
Subject of Report	**Task and finish group on future of Public Health Dorset: findings and recommendations from stakeholders**
Executive Summary	This paper summarises the findings of a series of interviews with Members of the Joint Public Health Board task and finish group on the future of the Public Health Dorset partnership. Members were in a high degree of agreement about the successes of the partnership to date, and the areas for improvement in future. The paper discusses some key development areas arising from the task and finish group, and presents recommendations from the moderation meeting as to how the partnership should evolve under Local Government Reorganisation.
Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: Not required, as no significant change is proposed to policy or services.
	Use of Evidence: Interview findings from Joint Public Health Board Members has been used to compile this report.
	Budget: The Public Health Grant for 2018/19 within the partnership agreement is £28.5m.

	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk: LOW
	Other Implications: None.
Recommendation	Members of the Joint Public Health Board are asked to note the task and finish group report's findings. In addition, Members are asked to support the following immediate recommendations: 1) Work with task and finish group members on a set of clear proposals by March 2019 for how the Joint Public Health Board will operate post-LGR. This is in order to better differentiate it from the work of the two Health and Wellbeing Boards. This work should include ensuring regular representation from Dorset CCG, and to explore the potential for future joint appointment of the substantive Director of Public Health between the CCG and Councils. 2) Approve the action plan attached as Appendix 2 in this report, which summarises the areas for development of the Public Health Dorset partnership, particularly those relating to working more closely with Members.
Reason for Recommendation	To continue to ensure that the Partnership functions effectively and efficiently to help deliver the legal public health duties of the new unitary Councils in Dorset.
Appendices	a) Action plan summarising areas for future development
Background Papers	Task and finish group on future of Public Health Dorset – a shared service model for Dorset, Bournemouth and Poole. Findings from interviews with stakeholders
Report Originator and Contact	Name: Sam Crowe Tel: 01305-225884 Email: s.crowe@dorsetcc.gov.uk

1. Background

1.1. The Joint Public Health Board agreed in 2018 to convene a task and finish group to look at the reviewing the public health partnership (Public Health Dorset) and identify areas for development in order to best support the new Unitary Councils.

1.2. Nine depth interviews were conducted by an independent research consultancy during the autumn, and a summary report produced with key findings. This report was considered at a moderation meeting on 24 October. Members agreed a series of recommendations, focusing particularly on areas for development to ensure the continued effectiveness of the partnership under LGR.

1.3. This brief report summarises the main findings and themes that emerged from the interviews. It includes two appendices – the report from the researchers, and a draft summary action plan for agreement by the Joint Public Health Board.

2. Review findings

2.1. Most interviewees said that the delivery of public health as a shared service over the past five years had been good. The Public Health Dorset function was seen as well managed and performing well, despite the nationally imposed 20 per cent budget reduction.

2.2. Commissioning of public health services was seen to have improved hugely since the transition of public health from the NHS to Councils. Eight of the nine respondents identified that the shared service approach had delivered clear benefits at scale, and the influence on strategic planning in the system.

2.3. Key strengths included leadership across the system, and particularly the work to embed prevention within the Sustainability and Transformation Plans. The benefits of operating the shared service at scale, pan-Dorset, were emphasised by a significant majority of those interviewed.

2.4. Areas for future development included understanding the importance of public health to the future success of the wider business of Councils and the NHS. In particular, there was a clear desire to see greater emphasis on health and wellbeing throughout corporate plans, decision making and delivery in the new Councils. In addition, interviewees consistently raised the importance of closer working with Members to enable them to fulfil their leadership roles. This included improving communication and co-ordination of efforts on Prevention at Scale, working closely with GP localities, and the Health and Wellbeing Boards, and other locality structures including Family Partnership Zones.

3. Next steps

3.1. At the moderation meeting to consider the draft report of the task and finish group, there was extensive discussion of some of the areas highlighted for development of the public health partnership.

3.2. These recommendations generally fell into two categories – those that could be enacted fairly quickly, relating to how public health Dorset currently operates, and those relating to the future operating model of the Joint Public Health Board. For example, ensuring the design of an engaging induction programme for new Members, improving communications and engagement with the public, involving Board members in

assessing priorities and setting direction in the annual business plan, and developing options for pursuing a health and wellbeing approach in the new Council(s) priorities, strategy and policies.

4. Recommendations

4.1. Members of the Joint Public Health Board are asked to note and support the task and finish group report's findings (Appendix A). In addition, Members are asked to support the following immediate recommendations:

- To work with task and finish group members on a set of clear proposals by March 2019 for how the Joint Public Health Board will operate post-LGR. This is in order to better differentiate it from the work of the two Health and Wellbeing Boards. This work should include ensuring regular representation from Dorset CCG, and to explore the potential for future joint appointment of the substantive Director of Public Health between the CCG and Councils.

- Approve the action plan attached as Appendix B in this report, which summarises the areas for development of the Public Health Dorset partnership, particularly those relating to working more closely with Members.

Sam Crowe
Acting Director of Public Health
November 2018

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Appendix A

Development area	Comments	Proposed actions	Target date for delivery
Develop how PHD works with Elected Members	Report identified need to work with Members further in advance of Board meetings, and to ensure wider group of Members understand public health	• Continue briefings with Portfolio holders but ensure forward plan is considered and developed jointly • Develop new Member induction content on public health function of Councils	April 2019
Include assurance on Health Protection function and responsibilities via the JPHB	Should include brief update on issues from Health Protection Network and other strategic fora	• Include health protection on new Member induction, and offer a development session in 2019	May 2019
Greater engagement with schools	Head Teachers Alliance Starting Well work – links with communications actions	• Board paper on work with Schools on forward plan of JPHB – to be developed with Member input	February 2019
Setting the agenda, priorities and business plan, including options and priority setting	Opportunity to tell a clearer story that links finance, outcomes and choices	• Invite Members to join business planning session for 2019/20 – for February Joint Public Health Board	February 2019
Improve communications and raise profile of public health work with Members and the public, to help them fulfil their leadership roles	We now have clearer resources for communications, and a strategy	• Refresh comms plan with Member input • Identify public health issues where joint work could improve public understanding and engagement (health checks, drug and alcohol services)	June 2019
Raise profile of public health by participating in scrutiny committees	Needs more consistent approach in the new model across both Councils	• Schedule key public health topics on scrutiny committees of both Unitaries – minimum once per year	April 2019

Appendix A

Improve integration of public health duty in new operating model for Councils including via a Health in all Policies approach	Need to understand how to do this effectively so that it is not just token, and does not lead to conflicting priorities	• Contact Local Government Association for support via the Sector Led Improvement programme to identify a development partner in a successful authority to work with	April 2019
Task and finish group recommendations for Governance (by March 2019)			
CCG to join Board as a key partner in the shared service service (mandation to provide public health advice to NHS)	There has been irregular and unclear attendance on Joint Public Health Board – should be formalised because of mandated service	• Work with CCG to ensure regular attendance on Board (named director)	March 2019
Clarity over DPH responsibilities and managerial relationships in new Unitaries – including corporate leadership role, line management and relationships with Cabinets	Need to understand how the evolving shared service model can provide clarity over the DPH role, while recognising that it can't work in exactly the same way as a single council service directorate	• Work with Members on a revised model for the partnership that ensures clear links between DPH and both top tier leadership teams and their Cabinets	March 2019
Clarify future operating model for the JPHB, to enable clear separation between strategic health and wellbeing work (Health and Wellbeing Boards) and assurance over public health delivery via the Public Health Grant (shared service model)	This should evolve as work on LGR progresses, and the place of Health and Wellbeing Boards within the governance for the ICS becomes clearer	• Task and finish group to consider different models – executive oversight as per Learning and Skills Board, vs continuing as a public meeting and shared executive	March 2019
Explore making DPH position a joint appointment between 2 Unitaries and the CCG / ICS	In the past, DPH appointments were usually joint between NHS and Councils	• Acting Director to raise this with CCG	March 2019

Task and finish group on future of Public Health Dorset – a shared service model for Dorset, Bournemouth and Poole

Findings from interviews with stakeholders

Miriam Maddison & Lyn Fisher
M Maddison Consulting Ltd
15th October 2018

1. Background

Members of the Joint Public Health Board agreed in July 2018 to run a task and finish group. This was in the context of local government reorganisation (LGR) and the creation of two new Unitary Councils to replace the current arrangements from April 2019. In addition, the area is a first wave Integrated Care System. The project considered how well the shared service model worked over the past five years, and aimed to provide some insight into how it could evolve to best support the new Councils and Integrated Care System.

2. Methodology

The task and finish group agreed the scope of the project and the framework of questions to be used in a series of interviews with 10 key stakeholders. This is attached as appendix 1.

An independent provider, M Maddison Consulting Ltd, was selected to conduct the interviews. The criteria for selection included good knowledge of the local government and NHS system in Dorset, Bournemouth and Poole and previous experience of working in Public Health elsewhere.

The Public Health team compiled a set of briefing information as background and this was sent to all those being interviewed.

Two interviewers conducted 9 semi-structured interviews, 7 by telephone and 2 face-to-face, during September and October 2018. The interviewees were elected members and senior officers representing the three existing upper tier Councils and the Clinical Commissioning Group (CCG).

One potential local government interviewee was contacted through a number of routes but did not respond to requests to take part in the process.

Interviewees were advised that their responses to questions would be written down and summarised, but not recorded, and that these responses would be anonymised in the written report and not attributed to any individual.

This report summarises findings from the interviews. It will be discussed with members of the task and finish group at a moderation meeting on 24th October 2018 and will then be used by the group to report to the Joint Public Health Board (JPHB) in November.

3. Summary of responses

Overall, the majority of interviewees felt that the delivery of Public Health (PH) over the past 5 years as a shared service has been good. PH was regarded as well managed and performed well during a period of significant change and the nationally imposed 20% reduction in budget. PH was felt to have made a positive difference in some areas of major service delivery for which they are responsible. System leadership was demonstrated in the influence on and strong contribution to the Sustainability and Transformation Plan (STP) and the profile of Prevention at Scale. The benefits of the service operating at a pan-Dorset level were emphasised by a significant majority of those interviewed.

The interviews also revealed some areas for future development. All highlighted the importance of PH to the success of the wider business of the Councils and NHS. There was a desire to see a greater emphasis on health and wellbeing throughout corporate plans, decision-making and delivery in the new Councils. Several interviewees consistently raised the importance of PH staff developing the way in which they work with Councillors, enabling elected members to fulfil their leadership roles. Many felt there are opportunities to communicate the work of PH more widely, to ensure all elected

members and senior managers are informed and engaged in supporting PH delivery, and that comprehensive and balanced information for decision-making is provided. Some suggestions were captured about how to address these issues. Communicating more widely with members of the public to raise awareness of the role and scale of PH was also proposed by several interviewees

No interviewees gave comments on the health protection function of the PH service without prompting during the interviews and no examples of this type of work were given. At national level the lines of responsibility between Public Health England and local PH services have not always been clear. However, in the opinion of the interviewers, the responses suggest that local arrangements for health protection could usefully be subject to assurance by the Joint Public Health Board.

4. Positive progress

Eight respondents specifically identified the pan-Dorset shared service as something they valued and that had delivered benefits from its scale of operation. Interviewees highlighted the importance for strategic planning, the ability to play a strong role in the STP, the benefits for some contracts and the benefits for the intelligence function. The positive impact on attracting and retaining professional staff was also noted.

Good progress was also identified in the following areas:

- **Management of the PH Grant.** All the interviewees felt that the PH budget had been managed well. Steady progress has been made on reducing costs and achieving more for less. The use of the grant was described as more focused, coherent and effective than when it first moved to the Councils. Financial reporting to the JPHB was felt to have improved over the past 2 or 3 years, now being clearer, more consistent and easier to follow at Board meetings. This has enabled members to compare budgets, and to agree with or challenge spending more effectively. Some spending in the past was not felt to have been providing value for money, and some outcomes were unclear. However, resources were now felt to be more targeted, spending was allocated differently, tighter controls were in place and PH was more accountable. Interviewees were pleased that priority areas appear to have been protected. Savings appear to have been made without any major problems evident in service delivery, and it was felt that members of the public would not be aware of savings made. Some further savings through LGR and internal restructure were anticipated.

- **Delivery and performance of PH function.** PH was felt to have made a significant and positive difference to some of the services for which they are responsible.

    - **Prevention**

    The majority of interviewees described the importance of the **Prevention at Scale** approach, whilst recognising the challenges of intervening earlier to achieve better outcomes. It was felt to be crucial as a means of delivery in the future, and as an important way of PH being seen to work. The work to embed Prevention at Scale in the STP and at the Health and Wellbeing Boards was commended.

    The Live Well programme was described very positively and seen as a key part of the PH programme for Prevention at Scale. The focus on areas of deprivation was welcomed along with the evidence of take-up of the service by individuals with higher need. One example given was work in Boscombe and the spin-off from Live Well in terms of a focus on men's health. Interviewees were keen to see more data as the service continues to

develop. The changes in arrangements for providing Live Well and bringing it back in-house were viewed positively.

Work in localities was highlighted by some interviewees. Examples were given of the PH team working alongside other colleagues in local communities in relation to early help, substance misuse and links to children's services. A specific example of beneficial work in schools in Poole on children and young people's mental health was given. Other examples included the benefits of PH's engagement in the regeneration work for Boscombe and West Howe.

- **Commissioning**

Commissioning was felt to have improved, being more targeted, evidence based and managed by competent and thorough staff. Some interviewees described the inefficient contractual arrangements the Councils inherited from the preceding NHS organisations and the opportunities that gave for rationalisation, especially in the context of the cuts to the PH grant.

The recommissioning of the **drug and alcohol service** was highlighted as a positive example by several interviewees. The new service was felt to be more targeted and more effective. Governance was felt to have improved as it was more centralised and not in separate places - this has reduced duplication and more members can contribute to debate. Flexibility in reporting was felt to be useful, with members being given separate data, but with the opportunity to request additional information if needed which has enabled better discussion.

Some interviewees cautioned that it was still too early to really know the impact from the changes to the drug and alcohol and sexual health services.

- **Enabling and supporting elected members in their leadership roles.** As noted above this is an area for development. However, experiences varied by Council. The most positive had been where the PH lead met regularly with the Cabinet lead member and was seen as very accessible and responsive. The PH lead was well embedded in the Council's senior team, with other PH colleagues visible in the organisation. The complexity for one set of officers to manage relationships across 3 councils was recognised and a view expressed that this should become easier with the move to the two new Unitaries. Many interviewees gave feedback that the Information provided at the JPHB had improved over the last year - it was identified as being easier to follow and provided a basis for support or challenge.

- **PH leadership across the wider system.** The approach to **Prevention at Scale** is detailed above. This was quoted by many as an example of the way in which PH were making a strong contribution to wider system leadership. The work being done was valued by the CCG. The role of PH in the STP was described as rebuilding the PH presence in the NHS, providing leadership and taking the plans in the right direction.

  The support from PH for **work with GPs in localities** was identified as a good start and an area for further development. The PH team were drawing a range of NHS colleagues in to working with the Councils. An example was given were they facilitated input from NHS staff at leadership sessions for Elected Member (for example from a GP, and a midwife discussing breastfeeding and helping women to stop smoking). This had helped bring PH to life and enabled members see how there is join up between areas.

One interviewee shared a specific personal example of the progress that was being made in general practice. *During a recent visit to the GP for a flu injection, she and her partner were also offered a blood pressure check, and were advised to monitor their blood pressure regularly in future - the GP used the opportunity given by a brief consultation to add value to the discussion and to make the intervention more effective. Both individuals felt they had received extra, relevant and timely advice.*

5. Areas which could be further improved

All the interviewees acknowledged the good progress of the shared PH service and offered views about how it could continue to do even better in the future.

- **Management of the PH Grant.** Some interviewees highlighted that they felt the decision-making about the reductions in the grant had been too managed. They would have welcomed more options in relation to setting priorities and weighting of different services before decision-making about how to apply the reductions.

- **Delivery and performance of PH function**

  - **Prevention**

    There was felt to be need to **improve communication and co-ordination** between the Health and Well Being Board, locality groups, and Family Partnership Zones. Locality groups were sometimes felt to be 'doing their own thing' (for example, teenage mental health was raised as a concern by several locality groups) and it was suggested that some issues could be better addressed at a pan Dorset level.

    More **engagement with schools**. It was acknowledged that work in this area was relatively new, but that there was potential to achieve more, for example, to encourage more pupils to be more active.

  - **Commissioning**

    Linked to the comments above on the wider prioritisation in the use of the PH grant, some interviewees felt that the approach to commissioning could be broadened to include more innovation and service redesign.

    The speed of some of the commissioning work was felt by some to be too slow. One example was the length of time it took to make the changes to sexual health services and another was the loss of some external grant funding linked to the work on drug and alcohol services.

    The challenges associated with **collecting and analysing data**, ensuring data collection systems were consistent and recording outcomes were highlighted. An example was given relating to exercise referrals – data should ideally be able to track source of referrals, any increase in physical activity, whether this is sustained and any longer term outcomes.

    Several commented on the current work on **Health Visiting and School Nursing** suggesting that the re-commissioning was still not yet where it needed to be and

that there had not been enough information in the Board about the impact of the changes.

The commissioning of **Health Checks** was also given as an example of work that had not gone so well, and a question was raised about their effectiveness, and whether their purpose was clear. Ambitious targets had been set for the programme, but it was noted that these should be met by targeting the right people, who could take steps to change less healthy behaviours, which could then make a positive impact on the decision of others (for example parents stopping smoking, which could in turn support children not to smoke). It was noted that there had been an opportunity to give feedback to the PH team about communication problems as part of the changes made and that the feedback had been taken on board.

- **Health protection**

  No interviewees gave comments on the health protection function of the PH service without prompting during the interviews and no examples of this type of work were given. Following prompting some interviewees thought the arrangements worked well. Another commented that the pan-Dorset arrangement for the service was beneficial for the health protection function.

  At national level the lines of responsibility between Public Health England and local PH services for this topic are not always clear. However, in the opinion of the interviewers, the responses suggest that an understanding of the local responsibilities and arrangements for health protection could usefully be subject to assurance by the Joint Public Health Board.

- **Enabling and supporting elected members in their leadership roles**

This was the area which generated the greatest feedback. Many interviewees commented that elected members could still be supported more to fulfil their leadership roles – whether as cabinet members or in their work in their local communities. The balance between the role of members and officers was not consistent and the PH team need to continue to develop their working style to **ensure PH is member led**.

Information for elected members. Information provided at the PH Board was felt to have improved but could still be further developed. Members need to be enabled to set the agenda and priorities for work, exploring and grappling with policy choices rather than an emphasis on being given briefings on service change decisions. It was suggested that PH could more fully present both sides of a proposal, rather than offering a protected or restricted viewpoint. Members should be more informed about risks and threats as well as strengths and opportunities, to then be in a position to make more informed and carefully considered decisions.

Several interviewees felt that elected members, unless directly involved in PH, may have very little idea about the function and scope of PH. Initial **training for new members** was reported to effectively cover safeguarding and other requirements, but could usefully include PH – what it is, what the budget is, expected outcomes, and how PH works in their communities. This could also be refreshed at mid term, for example through a member

engagement forum to provide updated information. It was also suggested that PH officers could be more evident in healthy place shaping meetings.

Some members without expertise in PH could benefit from **simpler language** or better explanation of acronyms and technical information in some reports.

Members involved in **Scrutiny** were perceived to have some knowledge of PH but were not engaged enough to be able to constructively challenge.

- **Communications**

  Generally, there was felt to be scope for better communication and messaging with members of the public about what PH do, who they work with and the impact that they can make. Several interviewees felt that there was relatively little understanding about the extent of the PH role, including how it integrates with the whole health and social care system. A concern was expressed about outside influences that were outside the control of PH locally, and that could have significant and often negative consequences. An example given was that some residents (and members) need to be better informed about drug and alcohol problems, and the value of drug and alcohol services. PH needs to continue to develop its profile – to be more visible and ensure residents see the value of its work.

- **PH leadership across the wider system**

  The CCG reflected that it was a **challenge for the NHS** when PH moved back to Local Authorities and that a hard-won focus on reducing variation was lost within the NHS in the first few years. However, that ground has been recovered with the current work on the STP.

  Several interviewees noted that the **CCG could be more involved** in the shared PH service given that it has a formal responsibility to provide support to the NHS.

  Although the approach to Prevention at Scale on a life stages basis ('Starting well' through to 'Ageing Well') was seen as very positive. However, it was suggested that this still needed to be able to identify and add some **local needs issues**, for example the high incidence of falls and surgery for fractured neck of femur.

6. How can PH Dorset most effectively support the future delivery of PH function and services to two new Unitary Authorities and the Integrated Care System?

The JPHB met in September 2018, during the interview process. At this meeting it was agreed to maintain the current arrangements for the Board and shared PH service from April 2019 for one year. The decision acknowledges that it will be for the new Unitaries to then make decisions about the future arrangements for Public Health.

There was strong support for a pan Dorset service – there was felt to be so much that has been positive in the current framework that it would not be good to lose it. Two interviewees commented on concerns about other discussions that were taking place about splitting the service but were not specific about these.

It was felt that existing members need to be provided with as much balanced information as possible (highlighting pros and cons) ahead of the new structures, and with as much flexibility in the system maintained so that the new administrations can decide upon the best model for the future.

PH still needs to make the case for spending in order to convince some other elected members of the value of PH – support is not universal and some members have other priorities (for example, adult social care).

The importance of helping to develop the target **operating models for the new Councils – raising the profile and presence of PH** was highlighted. A number of suggestions for the future were captured through the interviews. These included:

- **Health and Wellbeing in all decision-making**. Interviewees stressed the importance of ensuring health and wellbeing is at the centre of Council activity and corporate planning. Health and wellbeing should be considered in every decision. It was suggested that all policy decisions and service plans should include a PH impact assessment – highlighting and reporting on PH in this way would ensure that it becomes part of corporate policy and could not be ignored. Although it is evident in some areas, and in the thinking of many staff, this would serve to raise the profile of PH across all departments, and would help encourage positive interventions and discourage negative ones.
- **Locality working.** Many interviewees talked about the importance of continuing to develop the PH role to support locality working, being alongside elected members, other Council staff and community groups. Suggestions included identifying link PH staff for localities and keeping a focus through PH to help the GPs develop a 'locality lens' to accelerate work in primary care on population health. PH was described as the glue between localities and the wider Council functions.
- **New member induction.** There is an opportunity to plan now for development support for the Councillors who are newly elected in May 2019.
- **PH involvement in corporate leadership.** The service was still seen by some to be separate and removed from other Council functions, and it was suggested that it should become a more integral part of the Councils. The Councils need to establish **clear reporting for the Director of Public Health** and how the role will be part of two senior management teams. Similarly working arrangements for other PH team members need to be developed in a way that engages with colleagues from other Council departments, building on the best of current practice. **Office arrangements** could be adapted to try and overcome a physical sense of separation. Several interviewees referred to the service as being a bit isolated in Princes House in Dorchester. A suggestion was made about trying to follow the CCG's example of their twin base approach in which neither office is perceived to be an HQ.
- **Communications.** It would be useful to aim for a higher profile for PH communications and ensure they are linked even more to the Councils' corporate communications and the STP. Cabinet leads and local members could be utilised more to front communications and there should be more opportunities created to enable this.
- **Clarifying the roles of the JPHB and the Health and Wellbeing Boards.** A mixture of views were offered by interviewees. Some suggested that the JPHB should be more about governing the PH service with the policy and priority setting for Prevention at Scale sitting with the Health and Wellbeing Boards. A smaller membership was proposed to include the lead cabinet members and the DPH's line managers plus a representative from the CCG. The JPHB under this model would not need to hold meetings in public, helping to reduce bureaucracy, and would be dealing with budget oversight, service performance and the

running of the service for example skill mix and grading. Examples of similar shared service arrangements were given including adult learning, the youth offending team and aspire adoption.

Alternative views were expressed that the current JPHB mixes strategic and executive functions at the same time and that is not a balance that works well. One interviewee suggested that PH should not be treated as a service that is purchased by the Councils and that the DPH role and service function needs to be governed in the same way as other statutory functions and senior officers, through the relationship with the lead cabinet member, cabinet and committee structure including scrutiny and executive line manager in each Council.

Decisions taken to date by the JPHB about the future arrangements for the shared service clearly acknowledge there is more work to do to shape the future governance arrangements for the service, and that options need to be presented to the two new councils for decision.

Some interviewees suggested extending an invitation to the CCG to join the current JPHB meetings.

- **Strengthening profile in Scrutiny.** There is scope to strengthen how PH is scrutinised. It was suggested that both new authorities should have PH scrutiny once a year, and information/briefing sessions at the beginning of term and mid term.
- **System leadership.** PH can continue to build its role as an intermediary and catalyst for work on the wider determinants of health. It was argued that the shared service is well placed to make that happen. One suggested option for the future was that part of the PH service could provide a hub for a shared approach to strategic commissioning when it makes sense to plan on a bigger population footprint, making good use of the information and intelligence skills within the service and recognising the wider system changes in relation to integrated care.
- **Learning from others.** Some interviewees were interested in opportunities to better understand good practice from elsewhere in the country. It was suggested there may be potential to align more with other neighbouring authorities, to share good practice and learn from each other’s experiences.

Appendix 1 – Project brief and outline questions for interviews

Purpose

Update Members of the Joint Public Health Board on the remit and scope of the task and finish group, agreed approach, and interview questions

Proposed approach

The following steps will be used to draw out learning from the delivery of the public health service over the past five years, and look ahead to ensure the service is fit for supporting the two new Unitary Councils:

- Briefing information sent to Members (by 6th Sept)
- Interviews scheduled (Sept)
- Moderation meeting (October)
- Report to JPHB (19 November).

The Terms of Reference considered by the Joint Public Health Board in June also included a question about the future leadership and governance of public health, including links with the Health and Wellbeing Boards. It has been agreed that the potential options to help answer this question will be worked up as part of the partnerships workstream under the LGR programme, which is taking place between September and October 2018. We will consider options at the moderation meeting in October. Consequently this topic will not be directly included in the telephone interviews.

Briefing materials

Members will receive three background reports that the Public Health team has prepared, summarising some of the past achievements and progress made since transfer to Councils.

a) *The shared service model for Dorset, Poole and Bournemouth*
This describes how the shared service was established, and has evolved over the past 5 years. It also offers some comparisons with other models in England.

b) *Transforming commissioning and services*
How Public Health Dorset working with colleagues across the system have transformed a number of public health services, in meeting the challenge of national reductions to the public health grant. This includes health improvement services, sexual health services, drug and alcohol services, and the proposed changes to public health nursing services planned for 2019.

c) *Public health leadership in the system*
Describes how Public Health Dorset has supported Councils and the NHS to improve health and wellbeing, through Health and Wellbeing Boards, locality working, and the Prevention at Scale programme in the Dorset Integrated Care System. It also describes the role and development of the health protection function across the Dorset system, including the Local Health resilience Forum, Dorset Immunisations Board and the Dorset Health Protection Forum.

d) *Appendix on Resources*
Details of how the Public Health Grant has changed over the past five years, including staffing changes.

Interviews and questions

The Joint Public Health Board agreed that an effective way of gaining a variety of views from Members about the future of public health would be via telephone interview. The proposal is for these to be carried out by Miriam Maddison and a colleague of hers, Lyn Fisher, due to a combination of knowledge about the local system and experience of working in Public Health.

Question	Rationale
1. What is your overall impression of the way that public health has been delivered in the past 5 years as a shared service to Councils in Dorset?	General introductory question, allowing space for Members to comment and add personal reflections to the work.
2. How well has the Public Health Grant been managed in your view? Please consider savings made, investments in prevention, commissioning and service changes.	This is an important statutory responsibility for the service, and Director of Public Health on behalf of the Councils. The Grant has been cut by more than 20% since transition, requiring changes to services.
3. How well do you think that the public health function has performed overall, considering local issues, and the way services are delivered? What factors have influenced your rating? 4. Is enough information given in our board papers to help you judge this?	Level of understanding as to whether the public health function is addressing the right priorities, and amount of scrutiny this receives.
5. How well do you feel the current model has enabled Elected Members to be informed and involved in decision making for public health? 6. Could anything be improved in how we work with Members?	Functioning of the Joint Public Health Board, relations with portfolio holders and other Members
7. How effective do you feel Public Health Dorset has been in providing public health leadership across the system e.g. how we support Councils & NHS partners in various boards, programmes & strategic meetings?	Effectiveness in getting prevention more recognised and embedded in the wider system
9. Is there anything you would like to highlight as particularly successful about the current model of public health delivery?	
10. Is there anything you would like to highlight as requiring improvement about the current model of public health delivery?	
11. How do you think Public Health Dorset can most effectively support the future delivery of the Public health function and services to the two new Unitary Authorities in the future? What could be improved, thinking about the future as we move to two new Unitary Councils?	Thoughts on future leadership in the new Councils, particularly delivering a more visible presence

Sam Crowe

Acting Director of Public Health

August 2018

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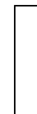
Public Health Dorset



Joint Public Health Board

Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	19 November 2018
Officer	Acting Director of Public Health
Subject of Report	**Community Health Improvement Services Procurement**
Executive Summary	Contracts for a range of community health improvement services are due to expire at the end of March 2019. This paper presents options for procurement and recommends a preferred approach that seeks to maximise efficiency and effectiveness of the services. The paper covers: • Background and rationale for change; • Options; • The Framework Model; • Risks and Mitigation plans; • Budget and timelines; • The preferred procurement option; • A recommendation to procure and award following successful completion of tender (delegated authority to the acting DPH to work with Portfolio holders to agree award).
Impact Assessment:	Equalities Impact Assessment: An equalities impact assessment screening tool has been completed. A full equalities impact assessment is not required.
	Use of Evidence: The commissioning update uses • Internal performance and data monitoring information • Evidence base for best practice guidance • Financial and service review recommendations

	• Risk assessment tools
	Budget: The annual budget for Community Health Improvement Services is £2,204,000.
	Risk Assessment: The financial risk is low. The main risks include building effective engagement with primary care and ensuring an effective invitations process and delivery across Dorset. Current performance in Dorset, Bournemouth and Poole is below national expectations for the programme. There is a reputational risk from continued poor performance in providing a mandated public health service, NHS Health Checks. Current Risk MEDIUM Residual Risk LOW
	Other Implications: None.
Recommendation	The Joint Public Health Board is asked to: • Approve the preferred option for procurement and award of the Framework Agreement for the provision of community Health Improvement Services; • Approve delegated authority to the Acting Director of Public Health Dorset in consultation with the Joint Public Health Chairs and Portfolio holders to award to appropriate providers. • Note that the Framework includes NHS Health Checks as per the recommendation of September 2018 Board. • Approve the procurement and award though Open Tender for provision of weight management support within the community • Note the risk and mitigating plans from cost and volume contracts • Agree to share these recommendations with the two Unitary Councils' Shadow Executive Committees.
Reason for Recommendation	To enable service continuation and transformation through procurement.
Appendices	Community Provider Health Improvement Services Business Case
Background Papers	None.
Report Originator and Contact	Name: Sophia Callaghan, Assistant Director of Public Health Public Health Dorset Tel: 01305-225887 Email: sophia.callaghan@dorsetcc.gov.uk

1. Background

1.1 In 2014/15 Public Health Dorset developed a dynamic purchasing framework for procuring community health improvement services. Most services with the exception of Health Checks were procured using an Any Qualified Provider (AQP) approach. Providers could apply for a specific public health contract, subject to meeting the essential criteria they were guaranteed a contract.

1.2 The dynamic purchasing system (DPS) has largely worked well. However, there are challenges and risks in managing some of the cost and volume contracts, including contraceptive services and smoking cessation.

1.3 The DPS and all associated contracts ends in March 2019 and these services will need to be procured under the Public Contract Regulations 2015. There is an opportunity to further improve how services can be delivered and engage providers to increase accessibility and activity where it is needed, within agreed budgets.

2. Options appraisal

2.1 The CHIS Services comprise of seven areas or Lots:

- NHS Health Checks
- Emergency Hormonal Contraception (EHC)
- Long-Acting Reversible Contraception (LARC)
- Needle exchange
- Supervised consumption of methadone and buprenorphine
- Smoking Cessation Services
- Weight management (to be discussed separately as there is a competitive market)

2.2 The Business Case for these Services in Appendix One outlines the strategic context and highlights the mandated contract regulations or national guidance which underpins the delivery of the different CHIS services in more detail for the Board. The business needs for these services are mainly to improve take up of evidence-based interventions, equity of service provision and quality of access.

2.3 Four possible procurement options are summarised below. The RAG system in the table has rated each option based on the principles of effectiveness, efficiency and equity, as follows:

- Red: Does not satisfy this principle
- Amber: Satisfies the principle to some extent
- Green: completely satisfies this principle

2.4 The local market for community services is generally from primary care and/or pharmacy providers. In choosing a preferred option the Board is asked to consider a which procurement approach most benefits effective delivery of these public health services.

2.5 Option 1: No change. Radical change is not required for most of the CHIS services. Therefore, for supervised consumption, LARC, EHC and smoking cessation no change could be an attractive option, because coverage across the county for these areas is comprehensive, and performance is good.

This is not true of health checks and needle exchange services. The current delivery of health checks is well below national expectations and will remain so without a new

approach (see previous paper, September Board). The current provision of needle exchange is reliant on a complicated payment system and poorly tailored equipment distribution for service users, both of which need simplifying. There is also the legal risk of being non-compliant with PCR 2015 when these contracts expire in March 2019. Therefore this option is not recommended.

2.6 Option 2: Single provider – award of contract to a single provider for all lots, or by activity area. This option could be effective in accomplishing an adequate scale of provision. However, a single approach may not be possible to achieve due to the complexities of adequate coverage and consistent quality of provision for Dorset to meet the varied population needs.

A single provider model might deliver some efficiency, but not necessarily the best outcomes for those trying to access services. A single provider model would not offer equity as it is likely that services would be complex and difficult to mobilise effectively across Dorset within budget.

2.7 Option 3: Locality based lots – potentially a different provider for each area of service, with tailored specifications. This option could be effective as it would tailor the offer. However, this may lead to issues around equity and quality for different population groups, as each locality may be set up with different provision. The known provider market are independent contractors and so this model may be too complicated to achieve equity. The use of competition at locality level could further fragment services. NHS health checks is one example of this challenge. This procurement option raises efficiency and management concerns, as it would be an intensive procurement and contract management process, with a significant number of locality lots required to ensure equitable coverage across 13 locality areas for each Lot.

2.8 Option 4: Any Qualified Provider (AQP) under an agreed framework. This means that any provider can deliver the service (provided they meet specific criteria), and will be paid according to activity. This model would offer a high level of efficiency, as it is a simple process, developed as a single framework with all six lots included. This framework is open to any qualified provider, and places the power in the hands of the end user to access services where they choose. This is a good fit with strategic objectives for Alcohol and Drugs and similarly with user choice and access for EHC and LARC contraception services. Given that all providers will offer the same service, according to the specifications, there would be providers across the county to deliver an equitable provision, leading to a highly accessible service.

There is the potential for this model to increase costs. However, the activity streams within most Lots are relatively straightforward. Some Lots have remained relatively stable and are not expected to increase. Those lots such as smoking cessation and NHS Health Checks need to increase and the projected budget should be able to accommodate this as the current spend is low.

2.9 Preferred Option: of the options under consideration, only Option 4 (AQP) increases the effectiveness, efficiency, and equity of current provision (see summary table, page 5). While options 2 and 3 both have a high potential for effectiveness, this is not matched by efficiency or equity, when option 4 is likely to be considerably more efficient. Option 4 includes no 'Low' scores for any of effectiveness, efficiency or equity.

Given the pressures on staff time and commissioning budgets being experienced at present, Option 4 simultaneously offers the potential to improve service and efficiency gains. For all service areas, it scores highest on efficiency.

3. Summary Table

	Option 1: No change			Option 2: One provider			Option 3: Locality lots			Option 4: Any qualified provider		
	Effectiveness	Efficiency	Equity	Effectiveness	Efficiency	Equity	Effectiveness	Efficiency	Equity	Effectiveness	Efficiency	Equity
Health Checks	Low	Medium	Low	Low	High	Medium	Medium	Low	Medium	Medium	High	Medium
Needle Exchange	Medium	Low	Medium	High	Medium	Medium	High	Low	Medium	Medium	High	Medium
Supervised Consumption	Medium	Medium	High	High	Low	Low	Medium	Low	Medium	Medium	High	High
Long-Acting Reversible Contraception	High	Medium	Medium	High	Low	Low	Medium	Medium	Medium	High	High	Medium
Emergency Hormonal Contraception	High	High	Medium	High	Low	Low	Low	Low	Medium	High	High	Medium
Smoking Cessation	Medium	High	Medium	High	Low	Low	High	Medium	Medium	Medium	High	Medium
Total*	7	7	6	10	3	2	7	2	6	8	12	7
	20			15			15			27		

4. The AQP Framework

4.1 The overall benefit of an ACP framework is that it is permissible under a light touch regime, which applies to Health Services where markets are known. It is flexible with a fixed price and allows for new entrants to be added at any time. The framework is not a competitive process, it is fair and is supportive, which will engage providers.

4.2 The process is simple, has one set of terms and conditions and all six community provider public health contracts can go under one framework. This would ease the procurement and provider application process and release capacity for planning more complex procurements such as Public Health Nursing services and Integrated Sexual Health services. Both the Local Medical Committee (LMC) and the Local Pharmaceutical Committee (LPC) support the approach, and it has played a significant part in re-engaging GPs with the NHS Health checks programme delivery.

5. Risks

5.1 A full risk assessment is outlined in the business plan. Key risks are:

- **Financial risk:** To Public Health Dorset if activity significantly increases and demand is subject to user choice.
- **Strategic Risk:** All Lots have importance to public health as mandatory services or to meet strategic requirements and poor activity increases risks for performance.
- **Reputational risk:** The model must be accepted by key partners and users or delivery could be compromised.

6. Mitigation Plans

6.1 The following mitigation actions are proposed:

- Modelling of likely activity has been undertaken to understand expected spend and budgets have been allocated accordingly.
- An outline of actual figures for Dorset or locality areas last year can be placed in the specifications of each lot to support provider business planning.
- There is an option to close the lots at any time and reopen.
- All lots on the framework will be monitored to ensure appropriate coverage and effective performance
- Consultation and communication plans with stakeholders and the public will ensure any reputational risk is mitigated.

7. Weight Management Services

7.1 The only community health improvement service where a different approach is proposed is for tier 2 weight management service, which will be retendered via a competitive process. The current provision is shown to be effective, efficient and comparatively equitable when compared with other models across the region. There is no case for radical transformation or change but there will be small changes to further improve effectiveness and efficiency. These include changing the payment model to pay only for used sessions rather than paying upfront for a 12-week voucher pack. We also intend to move providers towards digital vouchers/receipts rather than a paper-based voucher scheme. To improve equity of the new provision we will lead a focused marketing campaign to encourage greater uptake of the service by men.

8. Budget and timeline

8.1 The consultation process will start this autumn and is in progress with the LMC and LPC to help with engagement of local providers in the framework approach. The framework will need to be in place for selection from January 2019 ready for delivery 1st April 2019. Further provider engagement can take place in February to ensure service equity in areas of potential low uptake.

8.2 Public Health Dorset will develop and procure a Flexible Framework Agreement, set out the terms and conditions, develop a clear pricing schedule for delivery of the Lots and agree the criteria to be used for the Any Qualified Provider approach by December 2018.

8.3 The table on page 7 shows the spend on community health improvement services in 2017/18, split by provider sector. We are not anticipating significant change in the spend on these services for the coming years, with the exception of NHS Health Checks, which has been performing below expectations for the past three years.

<table>
<tr><th></th><th colspan="3">2017-18 Spend</th><th>2018-19 Budget</th></tr>
<tr><th></th><th>GP Practices</th><th>Pharmacies</th><th>TOTAL</th><th>TOTAL</th></tr>
<tr><td>Health checks</td><td>£162,232.00</td><td>£41,711.40</td><td>£210,707.40</td><td>£600,000</td></tr>
<tr><td>EHC</td><td></td><td>£116,311.92</td><td>£116,311.92</td><td rowspan="2">£784,000</td></tr>
<tr><td>LARC</td><td>£602,618</td><td></td><td>£602,618</td></tr>
<tr><td>Supervised Consumption/Needle Exchange</td><td></td><td>£295,265.53</td><td>£295,265.53</td><td>£300,000</td></tr>
<tr><td>Smoking Cessation</td><td>£33,730.00</td><td>£322,553.91</td><td>£356,283.91</td><td>£520,000</td></tr>
<tr><td>Total</td><td>£415,294.88</td><td>£775,842.76</td><td>£1,197,901.64</td><td>£2,204,000</td></tr>
<tr><td>Weight Management</td><td></td><td></td><td></td><td>£175,000</td></tr>
</table>

9. Recommendations

9.1 The Joint Public Health Board is asked to:

- Approve the preferred option for procurement and award of the Framework Agreement for the provision of community Health Improvement Services;
- Approve delegated authority to the Acting Director of Public Health Dorset in consultation with the Joint Public Health Chairs and Portfolio holders to award to appropriate providers.
- Note that the Framework includes NHS Health Checks as per the recommendation of September 2018 Board.
- Approve the procurement and award though Open Tender for provision of weight management support within the community
- Note the risk and mitigating plans from cost and volume contracts
- Agree to share these recommendations with the two Unitary Councils' Shadow Executive Committees.

Sophia Callaghan
Commissioning and Contracting Sponsor

Bournemouth, Poole and Dorset councils
working together to improve and protect health

Public Health Dorset

BUSINESS JUSTIFICATION

Community Health Improvement Services 2019:

Business Justification

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Purpose of this document

This document provides a template for business cases in support of small and medium size investments – typically those below £2 million whole life costs that are **not** novel or contentious in nature.

Please note that this template is for guidance purposes only.

VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
Draft	19.10.18	Draft for Project Team	Will Haydock
Draft 2	23.10.18	Draft for SMT	Will Haydock

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BUSINESS JUSTIFCATION TEMPLATE AND SUPPORTING GUIDANCE

1. Purpose

This business case is to seek approval to procure providers of a range of Community Health Improvement Services, namely:

Lot 1: Health Checks

This is a check designed for local residents aged from 40 to 74 years old, with some exceptions. The process, as laid out in government legislation, assesses a range of health factors, including smoking status, family history of coronary heart disease, body mass index, cholesterol level, blood pressure, physical activity levels, cardiovascular risk score, and alcohol consumption.

In 2017-18, 6,241 health checks were completed by GPs with a further 1,492 conducted in pharmacies.

Lot 2: Emergency Hormonal Contraception (EHC)

Emergency contraception can prevent pregnancy after unprotected sex or if the contraception you have used has failed – for example, a condom has split or you have missed a pill. EHC uses chemicals that affect the release of an egg, and therefore can prevent pregnancy. There were 5,620 EHC interventions delivered in 2017-18.

Lot 3: Long-Acting Reversible Contraception (LARC)

LARC refers to contraceptive methods that require administration less than once per cycle or month, specifically: copper intrauterine devices; progestogen-only intrauterine systems; progestogen-only injectable contraceptives; progestogen-only subdermal implants. Under the current contract, there were 7,695 instances of LARC in 2017-18.

Lot 4: Needle exchange

Needle and syringe programmes (NSPs) supply needles and syringes for people who inject drugs. In addition, they often supply other equipment used to prepare and take drugs (for example, filters, mixing containers and sterile water). The majority of needle and syringe programmes are run by pharmacies and drug services. They may operate from fixed, mobile or outreach sites. The main aim of needle and syringe programmes is to reduce the transmission of blood-borne viruses and other infections caused by sharing injecting equipment. They also reduce the risk to the public from discarded needles by providing the opportunity for disposal of used sharps.

In 2017-18, there were 17,497 visits to pharmacies for needle exchange.

Lot 5: Supervised consumption of methadone and buprenorphine

In some instances where an individual is prescribed medication to help treat a substance use disorder, clinical guidance recommends that the patient is observed while taking what is a potentially toxic medication, to reduce the risks to the individual concerned and the wider community. In 2017-18, 708 individuals were registered for supervised consumption.

Lot 6: Smoking Cessation

Several treatments are available to support people looking to stop smoking, including:

- Psychosocial behaviour change support, which offers people personalised support while they go through the process of quitting;
- Nicotine replacement therapy, which provides a low level of nicotine, without the tar, carbon monoxide and other poisonous chemicals present in tobacco smoke, reducing harm and reducing unpleasant withdrawal effects;
- Prescribed medication (i.e. Varenicline), which reduces cravings and blocks the rewarding and reinforcing effects of smoking.

In 2017-18, 841 people started a quit attempt with support from their GP, 359 people had quit at 4 weeks and 140 people had quit at 12 weeks. Through Pharmacies 2,286 people started the quit, 783 people had quit at 4 weeks and 489 people had quit at 12 weeks.

The overall cost of these services will be variable, dependent on activity. However, as an illustration, the total spend across these areas was approximately £1.1m in 2017-18.

	2017-18 Spend			2018-19 Budget
	GP Practices	**Pharmacies**	**TOTAL**	**TOTAL**
Health checks	£162,232.00	£41,711.40	**£210,707.40**	**£600,000**
EHC		£116,311.92	**£116,311.92**	**£784,000**
LARC	£602,618		**£602,618**	
Supervised Consumption/Needle Exchange		£295,265.53	**£295,265.53**	**£300,000**
Smoking Cessation	£33,730.00	£322,553.91	**£356,283.91**	**£520,000**
Total	£415,294.88	£775,842.76	**£1,197,901.64**	**£2,204,000**
Weight Management				*£175,000*

The current spend is considerably under budget, as current provision of particularly health checks is not meeting demand. It is anticipated that spend will increase in 2019-2020, as the payment schedules for some activities are updated to reflect current priorities and costs, and delivery of health checks should increase from what are currently low levels.

However, this should be manageable within current budgets. Within the current public health grant, £600,000 is allocated for health checks, with activity forecast to increase up to 15,000 checks annually – almost doubling activity compared to the 7,733 checks delivered through GPs and pharmacies in 2017-18. Therefore increased accessibility and activity should be delivered with no increase in budget.

2. Strategic Context

Health Checks

Under The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, it is stated that 'each local authority shall provide, or shall make arrangements to secure the provision of, health checks to be offered to eligible persons in its area.' Therefore some provision of health checks is required. This project seeks to fulfil this requirement.

EHC and LARC
The same regulations note the public health responsibility of local authorities to ensure there is 'advice on, and reasonable access to, a broad range of contraceptive substances and appliances'. Lots 5 and 6 under this proposed project would form part of the local offer, and are included in the format proposed because they are specifically cost-effective interventions (as discussed below).

In relation to LARC specifically, NICE guidance states: "Women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods."[1] Therefore some provision of LARC is required. This project supplements the offer through specialist services, for the reasons described in section 3 below.

Needle exchange and Supervised consumption
Lots 4 and 5 represent part of the commitment of Public Health Dorset to the Bournemouth, Poole and Dorset 2016-2020 Alcohol and Drugs Strategy. Specifically, one of the objectives of this was: 'For those who do use alcohol and other drugs, they do so in a way that reduces risks of immediate or long term health damage, including death.' 'Reducing the harm caused by drugs and alcohol' was also one of the 'wider priorities' listed in the Bournemouth and Poole 2013-16 Health and Wellbeing Strategy.

Nationally, needle exchange is identified in the 2017 Drug Strategy as a key requirement for local commissioners: 'Key to supporting improved health is action to prevent blood borne infections by vaccination (where available) and by maintaining the availability of injecting equipment through needle and syringe programmes'.

Supervised consumption is an essential element of a drug treatment system that delivers opiate substitution therapy (OST), as defined in the 2017 guidance "Drug misuse and dependence: UK guidelines on clinical management".

Smoking cessation
'Reducing the harms caused by smoking' was an objective of the 2013-16 Dorset Health and Wellbeing Strategy. Smoking cessation aims to reduce the number of people smoking in the local area, and therefore the harms associated with this.

3. Case for Change

A. Business needs

Please provide the compelling reasons for investment in the required services or assets, with reference to:

- *The investment objectives for the procurement*
- *The problems with the status quo.*

All the services included in this project are currently offered in some format. However, the contracts for this provision, including available extensions, expire in March 2019. Therefore any

[1] See https://www.nice.org.uk/guidance/cg30/chapter/1-Recommendations

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provision beyond this point will require new contracts to be put in place or alternative arrangements to be accepted.

Health Checks
As noted above, the offer of a health check to the eligible population is a mandatory part of local public health service delivery. Some form of offer is therefore required. Current provision is inequitable and unreliable, with some patients reporting waits of up to six months for an appointment. Uptake has been particularly low in some areas of the county, including priority areas for addressing health inequalities. Therefore it is proposed that changes are made in order to offer more accessible provision.

EHC and LARC
Local residents have access to a range of forms of contraception through primary care and specialist sexual health services such as GUM clinics. However, public health regulations state that as well as there being a choice in principle, there should be 'reasonable access to a broad range of contraceptive substances and appliances'. Primary care provision is offered through booked appointments, and specialist sites are more limited geographically and generally offer appointments with some drop-in sessions – but not in an open access format. Community-based provision, as currently delivered through pharmacies, is an open access ('drop in') service. The proposal will therefore mean that services are available in a wide range of locations at accessible times and places.

While LARC fittings would still be by fixed appointment, in the absence of this project LARC would only be available from the limited number of specialist sites. Therefore the project offers the opportunity to maintain genuinely accessible services for LARC.

Needle exchange
Under the core community treatment contracts for substance misuse, services already provide specialist needle exchange. However, NICE guidance for needle and syringe programmes recommends that there are both specialist programmes and 'community pharmacy-based needle and syringe programmes'.[2] This is recommended on the basis that specialist services will operate via a limited number of times and locations, and it is advised that 'services are offered at a range of times and in a number of different locations'. The proposal will ensure this recommendation is met.

The proposal will also incorporate disposal facilities for other client groups, such as diabetics who inject insulin, for whom the local authority holds responsibility in terms of waste disposal. This responsibility previously rested with PCTs and has not as yet been systematically absorbed by the local authorities.

Supervised consumption
For any system offering opioid substitution treatment, which the commissioned community substance misuse services do, supervised consumption of medication is required for a particular cohort of service users in order to ensure the safety of the individual and the wider community.[3]

[2] See https://www.nice.org.uk/guidance/ph52
[3] See https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

This should therefore be provided at accessible times and places to ensure continued compliance with treatment.

This project seeks to ensure there are providers able to offer this service across the local area. In addition, other models to deliver supervision will continue to be explored.

Smoking cessation
NICE and Public Health England have published guidelines for health practitioners and stop smoking services on the best ways to help people quit smoking.[4] The guideline includes evidence-based interventions that should be available to adults who smoke including: behavioural support; non-nicotine medications to help cravings and withdrawal symptoms; nicotine replacement therapy (NRT) and very brief advice. These are the elements of the service model that is being proposed as part of this project.

In addition, the guideline recommends prioritising specific groups who are at the highest risk of harm from smoking, such as women who are pregnant and people with mental health problems. This requirement is being taken forward through separate workstreams, where Public Health Dorset has worked with maternity and mental health services to develop pathways and protocols to ensure that those at the highest risk of smoking-related harm receive the support they need.

B. Benefits

*Please provide a summary of the **main** benefits associated with the investment, distinguishing between qualitative and quantitative; cash releasing and non-cash releasing; direct and indirect to the organisation, as appropriate.*

Health Checks
Key potential benefits of health checks include disease identification, changing health-related behaviour, increasing referrals to other health improvement services

Researchers at the University of Cambridge have conducted an evidence synthesis[5] on each of these points and found the following:

In terms of disease identification, one new case of raised blood pressure is found for approximately every three to four NHS Health Checks, with one new diagnosis of hypertension made for approximately every 30-40 NHS Health Checks. A new case of diabetes is made for every 80-200, chronic kidney disease between 60 to 600 and a person with a modelled cardiovascular disease risk ≥ 20% every six to ten. In the two studies that include only those with cardiovascular disease risk ≥ 20%, almost one in two NHS Health Checks resulted in a diagnosis of hypertension20,21. In all these studies though, is not possible to know how many of these are directly a consequence of the NHS Health Check or how many would have been identified within routine practice.

[4] See https://www.nice.org.uk/guidance/NG92
[5] The Primary Care Unit, University of Cambridge and RAND Europe (2017) NHS Health Check Programme rapid evidence synthesis, prepared for Public Health England.

In terms of changing health-related behaviours, the only factor consistently examined is smoking, and in this case there is a separate service to begin discussions with potential service users (LiveWell) and a separate lot proposed as part of this project to offer support to individuals who choose to take up this opportunity. Evidence suggests that prevalence of smoking reported in the medical records was not significantly different among attendees than non-attendees a median of two years after the NHS Health Check.

There is some evidence that reductions in risk factors for cardiovascular disease and other conditions are more substantial amongst patients who have attended a health check, along with prescribing of drugs such as statins to reduce risk and treat relevant conditions.

This suggests that health checks may have some effect on people's long-term health, and therefore costs across the health and social care system, though these are not likely to be cashable in terms of the public health budget.

EHC

Research suggests that EHC is cost effective. Based on analysis published in 2010 in the Journal of Family Planning and Reproductive Health, both ulipristal acetate (UPA) and levonorgestrel are cost effective based on avoiding the cost of an unintended pregnancy (£948).[6]

Therefore there are significant savings to the healthcare system, though these are generally not cashable by PHD or PHD-commissioned services.

LARC

In November 2016, increasing uptake of LARC one of just six areas where Public Health England identified preventative interventions estimated to improve health and wellbeing and save money to the health and/or care system within a five-year horizon.[7]

Current NICE guidance states that:

- all currently available LARC methods (intrauterine devices, the intrauterine system, injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use
- intrauterine devices, the intrauterine system and implants are more cost effective than the injectable contraceptives
- increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies.[8]

Therefore it is appropriate for LARC to be offered locally both on the basis of patient choice and cost effectiveness in comparison to other methods of contraception.

Needle exchange

NICE guidance states that delivering needle and syringe programmes (NSP) is cost effective in controlling HIV and reducing Hepatitis C prevalence, particularly when offered alongside

[6] See https://srh.bmj.com/content/familyplanning/36/4/197.full.pdf
[7] See https://www.gov.uk/government/publications/local-health-and-care-planning-menu-of-preventative-interventions (p.6)
[8] See https://www.nice.org.uk/guidance/cg30/chapter/Key-priorities-for-implementation

recruitment into OST. It is also recommended that NSP provision includes interventions to encourage clients to attend OST programmes.[9]

Therefore, given that Public Health Dorset does not commission HIV or HCV treatment or related services, these savings are not necessarily cashable. However, they reflect significant savings to the wider health and social care system, as well as society as a whole.

Supervised consumption

As noted above, supervised consumption increases the safety of service users on OST. Research suggests that in England and Scotland opioid-related deaths reduced fourfold after the introduction of supervised consumption.[10] This could deliver significant, if non-cashable, savings to society, and the offer of supervision is required if our commissioned services are to be able to deliver treatment in line with national guidance.

However, evidence for using supervised consumption by default is of relatively low quality, with researchers recommending that decisions as to whether OST should be delivered via supervised consumption or take-home doses should be made on a case-by-case basis.[11]

The project proposed would therefore offer the option for service users to access supervised consumption facilities as appropriate, with no requirement or guarantee of business for the providers concerned.

Smoking cessation

Current NICE guidance states that commissioners should ensure the following evidence-based interventions are available for adults who smoke:

- behavioural support (individual and group)
- bupropion
- nicotine replacement therapy (NRT) – short and long acting
- varenicline
- very brief advice.

NICE concluded:

> "Evidence showed that all the stop smoking interventions recommended for adults are effective. But to get the most benefit, staff delivering behavioural interventions must be trained to the NCSCT training standard. All the interventions are clinically effective, cost effective and cost saving to both the NHS and local authorities."[12]

[9] See https://www.nice.org.uk/guidance/ph52 and https://www.nice.org.uk/guidance/ph18/documents/needle-and-syringe-programmes-economic-modelling-revised-full-report-september-082

[10] Strang J, Hall W, Hickman M, Bird SM (2010) Impact of supervision of methadone consumption on deaths related to methadone overdose (1993-2008): analyses using OD4 index in England and Scotland. *British Medical Journal*, 341: c4851

[11] Saulle R, Vecchi S, Gowing L. (2017) Supervised dosing with long-acting opioid medication in the management of opioid dependence. Cochrane Database of Systematic Reviews 2017, Issue 4. Art. No.: CD011983. DOI: 10.1002/14651858.CD011983.pub2. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011983.pub2/full

[12] See https://www.nice.org.uk/guidance/ng92/chapter/rationale-and-impact#evidence-based-stop-smoking-interventions-2

Although these savings would not be cashable in terms of the public health budget, this project therefore seeks to procure these services with the specific requirement that staff delivering interventions have received appropriate training.

C. Risks

*Please provide a summary of the **main** risks associated with the investment, distinguishing between business and service risks during the design, build and operational phases of the project, as appropriate.*

See risk register below.

No	Risk Description	Risk Status *Open or Closed*	Risk Lead	Date Identified	Current Controls *How do we currently manage this risk?*	Current Risk *High / Medium / Low*	Movement Since Last Review *Improving / Deteriorating / No Change*	Is the current level of risk acceptable? *i.e. Yes or No, based on the current controls*	Any Issues to Highlight Since Last Review?	Further actions identified to achieve an acceptable level of risk	Target Date for further actions
1	**Financial: spend is determined by service user demand, with particular risks around health checks and supervised consumption, where it is anticipated activity will increase considerably over the period of this contract.**	Open	S Callaghan	18/10/2018	(i) Modelling of likely activity has been undertaken to understand expected spend, and budgets have been allocated accordingly (£600,000 for health checks in 2019-2020 compared to a spend in 2017-18 of £210,707). (ii) There is the option to close a lot for a period if there is overspend.	Medium	No Change	Yes	None	Review activity at the end of Q1 2019-2020 to check how likely increased demand is.	01/07/2019

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2	**Strategic: All lots have strategic importance to Public Health Dorset. In particular, smoking cessation is a key objective of the 2013-16 HWB plan and Health Checks are a mandatory requirement. If performance is poor, this puts at risk the delivery of PHD's strategic objectives**	Open	S Callaghan	18/10/2018	PHD monitor activity on a monthly basis and will dedicate staff resource, particularly in year 1 of contracts, to ensure coverage and mobilisation are sufficient to ensure adequate performance	Low	No Change	Yes	None	Review activity on an ongoing basis (monthly for PharmOutcomes users).	01/05/2019
3	**Reputational: Potential providers such as GPs are key partners for within the wider health and social care system. If PHD proposals for this project are not acceptable to this group, the reputation of PHD may be compromised, affecting joint working on other issues.**	Open	S Callaghan	18/10/2018	(i) Consultation with stakeholders prior to procurement going live to ensure potential concerns/issues are understood; (ii) Clear communication with potential providers about the process once finalised	Low	No Change	Yes	None	Review engagement of providers during procurement process	15/02/2019

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4	**Reputational: These are all public-facing programmes and members of the public have expressed frustration where they have been unable to access a health check, for example. Failure to provide an accessible service may affect the wider reputation of PHD, which is important for its role as a trusted provider of healthcare information**	Open	S Callaghan	18/10/2018	(i) Consultation with stakeholders prior to procurement going live to ensure potential concerns/issues are understood; (ii) Clear communication with the public once services are live to ensure they understand what they can expect and why the provision is arranged as it is.	Low	No Change	Yes	None	Review engagement of providers during procurement process Review activity to anticipate any temporary pause in activity being introduced to allow communication with providers and the public.	15/02/2019

5	**Service delivery: All services would be at risk if there is inadequate coverage across the area.**	Open	W Haydock	18/10/2018	(i) Consultation with potential providers prior to launch of procurement to ensure proposals are likely to be acceptable; (ii) The proposed framework will be open for 4 years, allowing plenty of time for potential providers to sign up; (iii) Any single lot can be closed with alternative provision arranged if the market does not provide acceptable coverage.	Medium	No Change	Yes	None	Review engagement of providers during procurement process	15/02/2019

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4. Available Options

Please provide a description of the main options (or choices) for investment, together with their relative advantages and disadvantages (a SWOT analysis).

Please bear in mind:

- *That a minimum of **four options** should be considered, including the 'do minimum' or 'do nothing' (unless there are compelling reasons to the contrary)*
- *That these options may differ in potential business scope, service solution, service delivery, implementation and funding, depending on the nature of the investment*
- *That the investment appraisal for each option should be contained as an appendix and prepared in accordance with the tools and techniques set out in the Capital Investment Manual and HM Treasury Green Book.*

Four possible procurement options are explained and assessed below. The options are rated according to how well the proposal meets each of the guiding principles of effectiveness, efficiency and equity, as follows:

- Red: Does not satisfy this principle
- Amber: Satisfies the principle to some extent
- Green: completely satisfies this principle

All options maintain the possibility of having different providers for each element, as the nature of the requirements are sufficiently different. Therefore, in choosing a preferred option decision-makers may feel that a single approach is not possible for all areas of activity. I.e. the option is available to choose a separate route for a particular 'lot' if required. Under the section below covering the preferred option, the specific lots where the preferred option is not clear-cut are discussed in detail.

The option of 'do nothing' in terms of providing no services is not presented here, as it would contravene the statutory requirements of the council, at least in terms of most services. The case for providing some element of service in all these activity streams has already been made in this document under sections 2 and 3. What is discussed, however, is the option of keeping the current arrangements in place – i.e. making no change.

Option 1: No change

Keep arrangements as they are currently without any procurement process

The proposals contained in the business case do not generally suggest radical change is required for most service areas under discussion. Therefore for supervised consumption, LARC, EHC and smoking cessation this could be an acceptable option. Coverage across the county for these areas is comprehensive, and performance is good.

In the case of supervised consumption and LARC, there may be opportunities to deliver services more efficiently in areas where there is more concentrated demand (i.e. urban centres), to avoid duplication where specialist services either already offer the service, or potentially could. Under the current arrangements there is not perfect equity of provision, but it is acceptable.

Two areas where this model is more challenging are health checks and needle exchange. Current delivery of health checks is well below Public Health Dorset's aspirations, and there is no indication that an improvement in performance would be possible while maintaining current arrangements. Pharmacies do not have access to the relevant data to target their offer, and initially uneven provision has combined with low activity rates as part of a vicious circle meaning that providers have not invested in making checks more accessible. The current provision of needle exchange is reliant on a payment system that is relatively complicated and not fully understood by providers, who have made it clear they would prefer a simpler payment structure.

Furthermore, there are legal issues with allowing the current arrangements to continue. The current contract will expire in March 2019 and there is no option to extend this further as all extension options have already been used. Any provision delivered beyond this point, without new contracts in place, would be on the provider's terms and conditions, with no ability to enforce training or quality, which have both been identified as potential areas for development by commissioners. Therefore, although the risks with this option are relatively low and provision is generally acceptable, this option is not recommended.

	Option 1: No change		
	Effectiveness	Efficiency	Equity
Health Checks	Current provision is poor in terms of both accessibility and reliability, with a small number of people accessing health checks, some individuals waiting up to 3 months for an appointment, and not all data being reliably collated and used within primary care.	The current provision does not require unreasonable input from commissioners to operate at this low level of performance, and the costs are relatively low (though only due to the low activity rates).	At present access to a health check is highly variable by locality.
Needle Exchange	Needle exchange is easily accessed from a wide range of sites. The quality of the intervention received, however, in terms of harm reduction advice and signposting to treatment, is relatively poor.	The pricing mechanism for needle exchange is complex and not fully understood by providers. The equipment distributed is not well tailored to all service users' needs, with the only units of supply available being packs of a week's equipment.	While provision is generally accessible across the area, and the same equipment is distributed to all, the needs of all service users are not identical, and therefore some may be better served by the system than others.
Supervised Consumption	There is good coverage and the interventions are generally delivered safely, though not with specialist drug worker input.	There is a considerable cost associated with this mode of provision, not only directly through this contract but also through dispensing costs that accrue to Public Health Dorset.	With good coverage across the county, and a comparable service, this is at present an equitable service.
Long-Acting Reversible Contraception	The current arrangements allow for access to LARC and provision is offered that is of high quality.	The delivery of LARC within primary care settings may not be as efficient as through specialist centres due to issues of scale.	Although coverage is not perfectly even, a comparable service is offered across most areas within the county.

Emergency Hormonal Contraception	The provision of this service through pharmacies is accessible and of good quality.	The use of a pharmacy setting, where the delivery of EHC fits with other comparable services, is highly efficient as it requires little additional resource outside of the delivery itself.	The quality of the provision (in terms of any associated counselling) will be partly dependent on the individual staff, and there is insufficient resource quality assure in great depth.
Smoking Cessation	The current provision is relatively effective, though it is not necessarily delivered by the most specialist, appropriate staff.	As with EHC, this mode of delivery is highly efficient as it is available alongside other services and does not require additional resource.	The quality of provision, given the potential importance of specialist talking therapies, may be variable, and not all pharmacies offer this service.

Option 2: Single provider

Conduct a procurement process seeking to award a contract to a single organisation, either for all lots or by activity area.

For most lots, this option has the potential to be highlight effective, as the scale of provision would allow for a certain level of specialism that these lots cannot provide when they are a small element of each local provider's work, as at present.

However, because levels and concentrations of need vary considerably across the county, a single approach or design may not be possible. If a blanket approach were used, while it might deliver efficiency, it would not, in fact, offer equity of provision, as it is likely that services would be more easily accessible and specialised in areas of concentrated need.

A more tailored approach, by contrast, would fail to deliver efficiency. However, the efficiency of the procurement process and ongoing contract management should also be noted: with only one provider this would be considerably more efficient for the Public Health Dorset in terms of internal team resources allocated to this process.

	Option 2: Single provider		
	Effectiveness	Efficiency	Equity
Health Checks	Experience with the current model of single providers for large areas, it would appear that this is unlikely to lead to accessible services being provided in the county.	A single provider model could be managed with a relatively low commitment of resource from PHD, and could deliver economies of scale.	It would be challenging for a single provider to genuinely offer an equitable service across the county as it would be difficult to provide venues and staff that were equally accessible in all areas for this one activity stream.
Needle Exchange	A single provider for needle exchange would be likely to have the technical expertise to improve the delivery of harm reduction interventions and signposting to treatment.	To deliver the maximum efficiencies, a single provider of needle exchange would be fully integrated with wider community drug treatment, which is not possible for 2019 given the timescales of other contracts.	

Supervised Consumption	There could be improvements in the quality and integration of the intervention if it were delivered by specialist drug workers, which would be more likely if this were a specialist provision.	In urban locations, a single provider could offer a highly efficient service, but this would not be possible outside of these areas, where it would be prohibitively expensive to administer on the very small scale required.	The difference between provision and accessibility in urban, as opposed to rural, locations would be pronounced.
Long-Acting Reversible Contraception	A specialist service could offer a highly tailored and effective service.	These interventions require considerable specialist expertise, and yet the scale of them is not such that they can be delivered by a single provider in isolation from other relevant services (e.g. dispensing of other drugs).	Without the use of existing services that operate in accessible locations, it would not be possible to provide a genuinely equitable service in all areas of the county.
Emergency Hormonal Contraception			
Smoking Cessation			

Option 3: locality based lots

Potentially a different provider for each area, possibly with a different tailored specification

This option could provide strong effectiveness, given the opportunity to tailor of the offer to each area. However, this may lead to some issues around equity, as each locality may be served differently, therefore scoring suggests this would generally be 'medium'.

The procurement option raises efficiency concerns, however, as it would be a considerably more intensive process, including in relation to contract management, with a significant number of locality lots required to ensure coverage across the whole area.

	Option 3: Locality lots		
	Effectiveness	Efficiency	Equity
Health Checks	Clarity about the location of provision in each area could improve take-up. A locality-based system could ensure the accessibility of services.	This model would require a relatively high level of commissioner input to manage the large number of lots, and no single provider would be guaranteed economies of scale.	If there were a sufficiently large number of lots, the accessibility of this service could be preserved for all areas. However, this would lead to challenges in ensuring the quality of provision across all areas
Needle Exchange	This option would allow for a more appropriate targeting of the offer to the specific needs in each locality.		While the targeting of the offer by locality could improve the effectiveness at the aggregate level, it would mean that the same options were not available to all service users.

Supervised Consumption	It is unlikely that this model would allow for provision by specialists, given the split into individual localities, and therefore the quality would not be improved from the current provision.		If there were a sufficiently large number of lots, the accessibility of this service could be preserved for all areas. However, this would lead to challenges in ensuring the quality of provision across all areas
Long-Acting Reversible Contraception	It is unclear whether the size of lots would lead to greater accessibility than specialist provision already in place.	Given the specialist nature of this provision, it is possible that having fewer providers could deliver some efficiencies.	
Emergency Hormonal Contraception	Lots would have to be prohibitively small to ensure the genuine accessibility of this service, given its emergency nature, as distinct from that provided through specialist services.	This model would require a relatively high level of commissioner input to manage the large number of lots, and no single provider would be guaranteed economies of scale.	
Smoking Cessation	This model might allow for more specialist provision, targeted to the specific needs of a local area.	Given the specialist nature of this provision, it is possible that having fewer providers could deliver some efficiencies. However, the additional contract management costs for PHD would be significant if the effectiveness improvements were to be delivered.	

Option 4: Any Qualified Provider (AQP)

Any provider that meets the criteria to deliver would be permitted to, and paid according to activity. The end user would determine where they wanted to access the service.

	Option 4: Any qualified provider		
	Effectiveness	Efficiency	Equity
Health Checks	Given the issues with single providers across large areas, it is possible this model might increase the accessibility of the intervention.	This model would be highly efficient for PHD in terms of procurement, and in terms of the providers, would lead to services being offered as part of wider work, rather than being set up as a dedicated project.	While this model would mean that in theory every customer would receive the same service, there is still likely to be variation in quality.
Needle Exchange	While this model would not lead to provision by specialists, it is likely that there would be an accessible service of good quality as at present.		While provision is generally accessible across the area, and the same equipment is distributed to all, the needs of all service users are not identical, and therefore some may be better served by the system than others.
Supervised Consumption			As at present, this is likely to be an accessible service that is comparable across all areas of the county.

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Long-Acting Reversible Contraception	Given the expertise of the providers, this would offer a reliably effective service that is likely to be accessible.		While this model would mean that in theory every customer would receive the same service, there is still likely to be variation in quality.
Emergency Hormonal Contraception	The key to the effectiveness of this provision is that it is delivered in a timely fashion. This would be more likely with the coverage this model should afford.		
Smoking Cessation	While this model would not lead to provision by specialists, it is likely that there would be an accessible service of good quality as at present.		

This model would offer a high level of efficiency in terms of the procurement process, as it can be relatively simple and places the power in the hands of the end user. In offering the responsibility of choice to the service user, AQP is a good fit with the Alcohol and Drugs Strategy objective: ‘Ensure people are able to access appropriate treatment and harm reduction interventions at times and places fitting their needs.’ Given that all providers should offer the same service, and there would be numerous providers across the county, this should offer equitable provision.

The approach of allowing any qualified provider to offer the service should open up provision to the widest possible number of providers and locations, therefore leading to a highly accessible service. The risks with this model are therefore that the costs may increase, despite the efficiency gains (methods to mitigate this risk are covered under the relevant section of this business case), and that, given the sheer number of potential providers, quality assurance may prove to be a challenge. However, several of these activity streams are relatively straightforward provided that the staff have the appropriate knowledge, skills and training.

In summary, in terms of effectively meeting the need of patients across the Pan Dorset area, this model is based upon an idea that the customer ultimately oversees where the business is activated. However, this is dependent on the quality of provision in reality. Therefore, ensuring appropriate training of provider staff would essential in making this model work to its maximum.

5. Preferred Option

On the basis of the above, please:

- *State why the recommended option optimises value for money(VFM)*
- *Describe the services and/or assets required.*

Of the options under consideration, only Option 4 (Any Qualified Provider) increases the effectiveness, efficiency, and equity of the current provision. While options 2 and 3 both have a high potential for effectiveness, this is not matched by efficiency or equity, when option 4 is likely to be considerably more efficient. Option 4 includes no ‘Low’ scores for any of effectiveness, efficiency or equity.

Given the pressures on staff time and commissioning budgets being experienced at present, and anticipated to continue during the course of the proposed contracts (4 years), it would appear that

Option 4 simultaneously offers the potential for improvements in service and efficiency gains. For all service areas, it scores highest on efficiency.

Despite this potential for efficiency, however, Option 4 does entail some risks. Given that spend will be determined by activity, and the choice of provider and level of activity is in the hands of the service user, there would appear to be little potential control of the budget for commissioners. However, as outlined in the risk assessment, there are opportunities to mitigate this risk, and indeed halt any further payments and activity if required.

For only two proposed lots is Option 4 not the highest scoring. Needle exchange would be equally well served by Option 2 (One Provider), while smoking cessation would be well placed under Option 3 (Locality Lots). However, Option 3 for smoking cessation would sacrifice the likely efficiency of Option 4. Moreover, this would not be possible without other lots following suit, as smoking cessation would be isolated from the other lots being provided, would likely reduce take up by providers, as they would have to go through a separate process simply for smoking cessation, which advice suggests would not be viewed positively.

In terms of needle exchange, Option 4 on its own will not deliver the optimum level of efficiency, and Option 2 would deliver a higher level of effectiveness, due to the specialism that could be employed. This potential lack of effectiveness is a concern, given the importance elected members in Bournemouth and Weymouth have placed on the issue of drug-related litter. Therefore, it is suggested that in addition to the proposed any qualified provider, a review is conducted to consider the specific issues regarding public injecting and drug-related litter in urban centres such as Weymouth and Bournemouth.

	Option 1: No change			Option 2: One provider			Option 3: Locality lots			Option 4: Any qualified provider		
	Effectiveness	Efficiency	Equity	Effectiveness	Efficiency	Equity	Effectiveness	Efficiency	Equity	Effectiveness	Efficiency	Equity
Health Checks	Low	Medium	Low	Low	High	Medium	Medium	Low	Medium	Medium	High	Medium
Needle Exchange	Medium	Low	Medium	High	Medium	Medium	High	Low	Medium	Medium	High	Medium
Supervised Consumption	Medium	Medium	High	High	Low	Low	Medium	Low	Medium	Medium	High	High
Long-Acting Reversible Contraception	High	Medium	Medium	High	Low	Low	Medium	Medium	Medium	High	High	Medium

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Emergency Hormonal Contraception	High	High	Medium		High	Low	Low		Low	Low	Medium		High	High	Medium
Smoking Cessation	Medium	High	Medium		High	Low	Low		High	Medium	Medium		Medium	High	Medium
	7	7	6		10	3	2		7	2	6		8	12	7
	20				15				15				27		

**Scoring Low as 0, Medium as 1, High as 2*

6. Procurement Route

Please state how the asset or service will be procured in accordance with the Government Procurement Agreement (WTO) and the EU Consolidated Public Sector Procurement Directive (2004).

This may involve the use of an existing contract; a call-off contract or framework agreement; or the requirement for a new procurement under the above.

It is proposed that a flexible framework agreement is used, with separate lots for each area of activity. This arrangement has strengths and weaknesses as outlined below:

Strengths	Weaknesses
Maximum potential coverage	No guaranteed quota/income for providers
Fair to whole market	Requires ongoing management/administration
Allows for new entrants	No price competition
Focus on End User choice	Fixed performance criteria
Simple for providers to complete applications	Delivers only basic service requirement

This proposal requires approval from the Joint Public Health Board.

There will be one set of Framework terms and conditions, and one procurement document (explaining the Framework model), but a specification for each lot.

There will be a fixed price for each unit of activity for each lot, and a pass/fail evaluation to identify the qualified providers based on a set of minimum criteria.

The light touch regime permitted by Contract Regulations for Health Services allows for Framework Agreements to be modified. In this case the modification will be that new applications to join the Framework will be permitted at any time. This will help mitigate the risk that there is inadequate or inequitable coverage of providers.

7. Funding and Affordability

Please indicate:

- *The capital and revenue costs of the proposed investment*

- *How the investment will be funded*
- *Any affordability gap (as appropriate).*

The proposed model of delivery is not expected to have a significant impact on budgets or costs. Current expenditure on these activity streams is under budget, because poor engagement and performance (particularly in relation to health checks) has meant that less activity has been billed for than was hoped. Therefore, there is capacity within the current budget for activity levels to increase considerably. For example, the 2017-18 budget for health checks was £600,000 compared to an actual expenditure of £210,707.40.

The investment in the new services will be funded, as at present, through the allocation of the Public Health grant made to Public Health Dorset. The aim is that overall this is relatively cost neutral. However, potential increases in spend in relation to health checks, supervised consumption and needle exchange have all been noted.

For health checks, the option remains to close down the lot for a period, if the limit on spending has been reached.

For supervised consumption, commissioners and providers are exploring alternative, more efficient solutions to dispensing drugs as part of a broader review of how treatment services can increase the number of people engaged in Bournemouth.

For needle exchange, it is the change in pricing structure that may increase costs. However, other changes to the equipment being distributed may deliver savings against which this can be offset. Nevertheless, there may be a risk of up to £10,000 as outlined elsewhere.

The public health grant is determined on a year-by-year basis, and therefore the allocated budget for this activity stream may change over the four year period of the contracts. In order to mitigate this risk, the same strategies can be applied as would be for activity-led cost pressures. That is, any lot can be terminated at any time and alternative pricing or provision can be explored and developed. For several of the services where a gap in availability would be challenging, there is already alternative provision available through primary care and specialist services (e.g. LARC, EHC). This has the potential to reduce the accessibility and equity of the service, as discussed above, but it would continue to provide some offer while alternative models of provision were put in place.

8. Management Arrangements

Please indicate how the investment will be delivered successfully with particular reference to:

- *Project management arrangements*
- *Business assurance arrangements (if applicable)*
- *Benefits realisation monitoring*
- *Risk management*
- *Post project evaluation (if applicable)*
- *Contingency plans (if applicable).*

Project management is being undertaken as follows:

Sophia Callaghan	Project sponsor
Will Haydock	Project manager

Darryl Houghton	Payment processes
Vicky Nichols	Financial information
Hayley Haynes	Data analysis
Gaby Lever	Project administrator

In addition to these staff, individual theme leads are involved in overseeing the work for their specific areas:

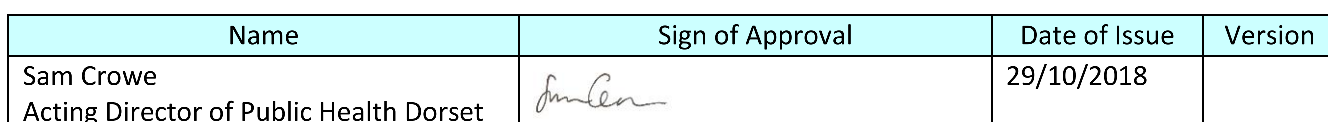
- Health checks: Susan McAdie
- Needle exchange: Will Haydock
- Supervised consumption: Will Haydock
- LARC: Jenni Lages
- EHC: Jenni Lages
- Smoking cessation: Stuart Burley

Ongoing management of the framework will require:

- Providers can send in a new application at any time
- This will use the message field in the e-procurement portal (Supplying the south west)
- Evaluation of qualified providers (pass/fail)
- Send notification of place on Framework (lots qualified, rates etc.)
- Assess invoice claims and check work delivered

Support for this function will be provided by business support and the procurement business partner. Ongoing analysis of activity and financial data will be conducted in-house using current staff as under the project management team. The project team will produce a post project report in summer 2019, reflecting on the service provision once the contracts are live. It is therefore essential that staff resource is allocated to the ongoing contract management and evaluation of these services.

Approvals This document requires the following approvals.



Name	Sign of Approval	Date of Issue	Version
Sam Crowe Acting Director of Public Health Dorset		29/10/2018	

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Joint Public Health Board

Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	19th November 2018
Officer	Acting Director of Public Health
Subject of Report	**Health Improvement Services Performance Monitoring Report**
Executive Summary	This report provides a high-level summary of performance for LiveWell Dorset, Smoking Cessation, weight management services, health checks and children and young People performance, with supporting data in appendices. A report on Health Improvement services performance will be considered every other meeting.
Impact Assessment:	Equalities Impact Assessment: Equality impact assessments are considered as part of the commissioning of our clinical treatment services.
	Use of Evidence: This report has been compiled from a range of local and national information, including NDTMS, PHOF and other benchmarking data where possible.
	Budget: Services considered within this paper are covered within the overall Public Health Dorset budget. Most of the Health Improvement Services are commissioned through either indicative figures or cost and volume type contractual arrangements. None of these contracts currently includes any element of incentive or outcome related payment, however good performance will ensure that we achieve maximum value from these contracts.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified

	as: Current Risk: LOW Residual Risk LOW
Recommendation	The Joint Board is asked to consider the information in this report and to note the performance on health improvement services and children and young people's services.
Reason for Recommendation	Close monitoring of performance will ensure that health improvement services deliver what is expected of them and that our budget is used to best effect.
Appendices	Appendix A: LiveWell Dorset, Weight Management and Smoking Cessation performance report Appendix B: Health Checks performance report
Background Papers	
Report Originator and Contact	Name: Sophia Callaghan, Assistant Director of Public Health Public Health Dorset Tel: 01305-225887 Email: sophia.callaghan@dorsetcc.gov.uk

1. Background

1.1 At the Joint Public Health Board in June it was agreed that the future Governance functions for Drugs and Alcohol would be carried out by the Joint Public Health Board. The principal function is monitoring of performance, and the Board requested a report every six-months. This started in September where the Board reviewed the Clinical Treatment services performance.

1.2 Given this request, it seemed timely to review our overall approach to performance monitoring, with regular reports focusing on our other high value contracts in turn. This report provides an overview of health improvement services and children and young people (0-19) services.

1.3 Alongside this the Board will also receive regular updates against the 2018/19 Business Plan to monitor progress against agreed deliverables.

2. LiveWell Dorset

2.1. The LiveWell Dorset service is a pan-Dorset integrated health improvement service, delivering consistent, high quality behaviour change support for people wanting to quit smoking, lose weight, be more active and drink less alcohol. It has supported over 20,000 people, engaging those most in need in help, and has recently launched a suite of additional digital options which complement the telephone advice and coaching.

2.2. LiveWell Dorset was initially a commissioned service, provided by Optum for 3 years. In April 2018 the service was successfully transferred in-house and has since been directly delivered as part of the Public Health Dorset offer. Directly delivery of the service has accelerated the development of key technological innovations, strengthened capacity at no additional cost, and has improved the alignment of the service with key Prevention at Scale objectives in the Integrated Care System.

2.3. Service activity has steadily increased in the last 3 months with continued strong engagement in the most deprived communities. This has been driven by improved marketing, successful launch of the new digital platform (3,000 visitors per month) and greater efficiencies which has increased frontline delivery capacity. Client reported outcomes data shows that around 75% of individuals are supported to make positive changes to behaviour such as stopping smoking, losing weight and becoming more active. More needs to be done to improve the capture of follow-up data at 3, 6 and 12 months. More detail on the latest performance data is available in appendix 1.

3. Weight Management Services

3.1. The rate of adults that are overweight and obese has risen sharply in recent years and is projected to continue to do so. High body mass index (BMI) is now the leading cause of morbidity in England – having overtaken smoking. Public Health Dorset commissions weight management services for people with a BMI of 30+. This is delivered by national providers – Slimming World and Weight Watchers – as well online provision by Rosemary Conley. LiveWell Dorset provides access to these services, delivers concurrent behaviour change support, and monitors outcomes over time.

3.2. The current services have been in place since May 2017 at a cost of £175,000 per year and are due to expire 30th April 2019. Performance monitoring of the contracts demonstrate that provision is considered to be high quality and effective in respect of

the number of individuals achieving targeted weight loss and in engagement of individuals residing in areas of greater deprivation. More details on the latest performance data is available in appendix 2.

3.3. Comparisons of the current provision with other services across the South West region suggests that it is effective, efficient and comparatively equitable. The commissioning intention is therefore to renew similar services albeit with some minor change to further improve efficiency and equity. Changes include a better digital offer, modifying the payment structure to reduce wastage, and improved marketing to under-represented groups.

4. Smoking Cessation

4.1. The prevalence of smoking continues to decline locally as it does nationally. This is driven by more people successfully quitting, fewer young people taking up smoking and a greater switch in use towards vaping products. Despite the gains being made, smoking remains the second leading cause of morbidity and early death.

4.2. Public Health Dorset commissions smoking cessation services to support people with psycho-social, behavioural interventions alongside Nicotine Replacement Therapy (NRT) or pharmacotherapy (Champix). This provision is supported by NICE as the most effective and efficient treatment available. Local services are provided by GPs, pharmacies and LiveWell Dorset to ensure that provision is accessible.

4.3. Access to services is good. The number of people accessing local smoking cessation services has increased, in contrast with national trends, and despite falling numbers of smokers. Services are also engaging a higher than average number of people from deprived communities. The rate of successful quitters is lower than the national average and has fallen in recent years so this remains the key performance challenge. Audit work has revealed that this may be due to delays in providers reporting data but more work needs to be done to explore this. Despite a low rate of success, locally there is an increasing number of successful quitters over recent years, compared with a decline nationally. More details on the latest performance data is available in appendix 3.

4.4. Recommissioning of current smoking cessation services is focused on growing provision in underrepresented areas, restructuring the payments to providers to ensure greater efficiency, improving success rates by providing better integration of community GP and pharmacy services with LiveWell Dorset, and improving data reporting processes.

5. Health Checks

5.1. Local Authorities are mandated to provide the NHS Health Check programme under the 2012 Health and Social Care Act. One of the consequences of local authority commissioning of the programme is that the way in which NHS Health Checks are procured is subject to Public Contract Regulations 2015.

5.2. As reported to the Board in a separate paper in September, current performance for delivery of NHS Health Checks remains variable across Dorset. As part of the programme mandate, Public Health England (PHE) requires Local Authorities to report the percentage of the eligible population invited and checked each quarter. Dorset, Bournemouth and Poole are currently ranked among the lowest of all local authorities (141, 148 and 133th respectively of 152 LAs).

5.3 In 2016/7 the programme across Dorset recorded 7,898 checks delivered overall and in 2017/8 there were 7,407 checks delivered. The PHE expectation for the financial year 2016/17 was to invite 46,456 people and deliver 23,228 checks, and for 2017/8 it was to invite 47,325 and deliver 23,663 checks. A breakdown of specific activity broken down by GPs and by pharmacy was outlined in the September Board paper and an overview is given in the data performance appendix.

5.4 The current contracts will end 31 March 2019. The total value of the health check budget for 2019/20 has been set at £600,000. This would enable up to 15,000 checks to be delivered each year, allowing for additional costs of invitations. While not meeting the national expectation of 23,000 checks delivered each year, achieving this number would be a significant improvement on the current position. This budget figure and to procure and award an AQP model was agreed by the Board in September

6. Children and Young People's Public Health Nursing Services (0 – 19 years)

6.1. Getting a good start in life and throughout childhood, building resilience and getting maximum benefit from education are important markers for good health and wellbeing throughout life. Health visitors and school nurses have a crucial leadership, co-ordination and delivery role within the Healthy Child Programme. They work with key partners to deliver comprehensive services for children, young people and families.

7. Main changes to commissioning/service

7.1. The Joint Public Health Board in June 2018 approved the recommendation to develop a procurement strategy for developing a Public Health Nursing (0 – 19) Pan-Dorset Service. Initial Market Consultation and Stakeholder Consultations have taken place over the summer 2018 and have been invaluable to developing both an effective procurement approach and proposed service model. Public Health Dorset are working with partners in the three Local Authorities, CCG and NHSE to develop the final service specification.

8. Summary of performance

8.1. The Health Visiting service in Bournemouth, Poole and Dorset is high performing when compared with other services in England. Overall, parents and carers express high levels of satisfaction with the service including consistent messages, having the right information to hand, and knowing where to access the service.

	Pan-Dorset
Percentage of all births that receive a face to face NBV within 14 days by a Health Visitor	90%
Percentage of children who received a 6-8 week review by the time they were 8 weeks.	96%
Percentage of children who received a 12-month review	97%
Percentage of children who received a 2-2½ year review	97%

Table 1. Performance on mandated checks, quarter 1 (2018/19).

8.2. The ***School Nursing*** service have successfully implemented key changes proposed through the review. Young people express positive experiences of the service, specifically the CHAT Health Text Service.

	Bournemouth	Poole	Dorset
Number of children and young people supported by **universal services** by Bournemouth, Poole and Dorset	23558	18857	58445
Number of children and young people supported at **universal plus services** by Bournemouth, Poole and Dorset	239	131	259
Number of children and young people supported at **universal partnership plus** services by Bournemouth, Poole and Dorset	13	2	21
Number of children and young people supported at **universal partnership plus statutory** services by Bournemouth, Poole and Dorset	708	557	1494

Table 2. Number of contacts by identified level of need, quarter 1 (2018/19) –

8.3. Between 1st April 2018 and 30th June 2018, a total of 465 text messages from young people have been received into the ChatHealth System as set out below:

Month	No. of ChatHealth Messages Received
April 2018	95
May 2018	149
June 2018	221
TOTAL	**465**

8.4. The top six reasons young people are contacting the ChatHealth System were:

- Self-harm
- Medical – Other
- Emotional Wellbeing
- Anxiety
- Depression or Low Mood
- Relationships.

9. Conclusion and recommendation

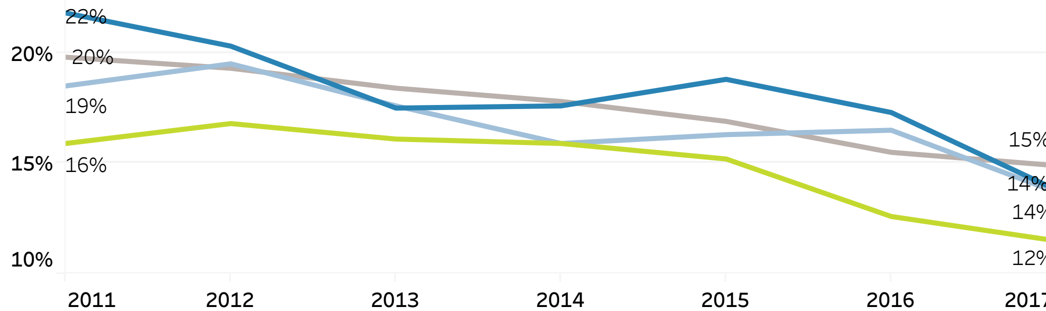
9.1. This paper provides a high-level summary in narrative form. Appendices include supporting data and information, with more in-depth information available on request. The Joint Board is asked to consider the information in this report and to note the performance on health improvement services and children and young people's services.

Sophia Callaghan
Assistant Director Public Health

November 2018

JOINT PUBLIC HEALTH BOARD SMOKING PERFORMANCE REPORT

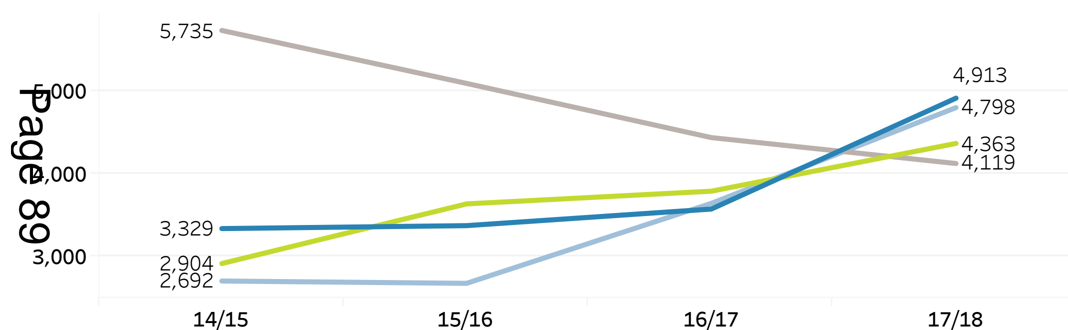
1. PREVALENCE: Percentage of adults smoking



The number of people smoking continues to decline. The decrease has been driven by more people quitting smoking, fewer younger people starting, and the recent popularity in vaping products.

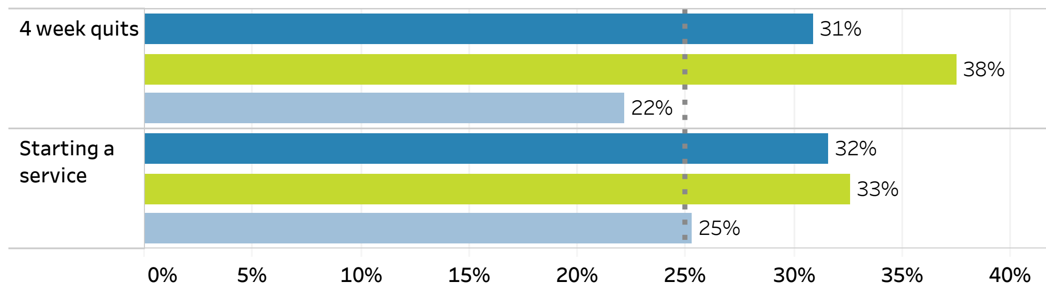
Area Name
- Bournemouth
- Dorset
- Poole
- England

2. SCALE: Persons starting a smoking cessation service per 100k smokers



Despite the decrease in smoking prevalence, we have seen an encouraging increase in the number accessing local services, in contrast with national trends. Access to services appears to be good.

3. REACH: Percentage in smoking cessation services living in the most deprived quintile 17/18



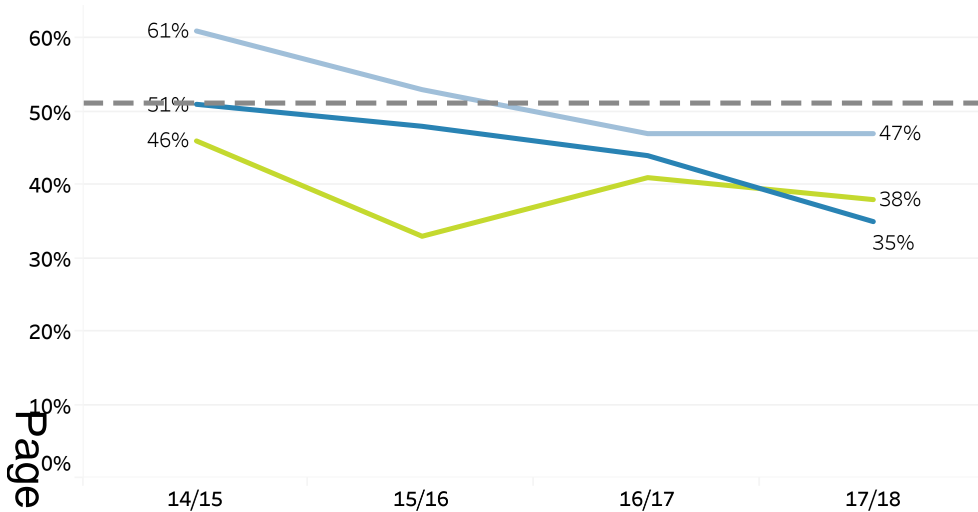
The prevalence of smokers in the most deprived quintile is almost double the national average. Local services appear to be effective at engaging those from deprived communities.

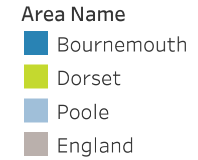
Created and maintained by the Public Health Dorset Intelligence Team
Data Source: PHE Fingertips

Bournemouth, Poole and Dorset councils working together to improve and protect health

JOINT PUBLIC HEALTH BOARD SMOKING PERFORMANCE REPORT

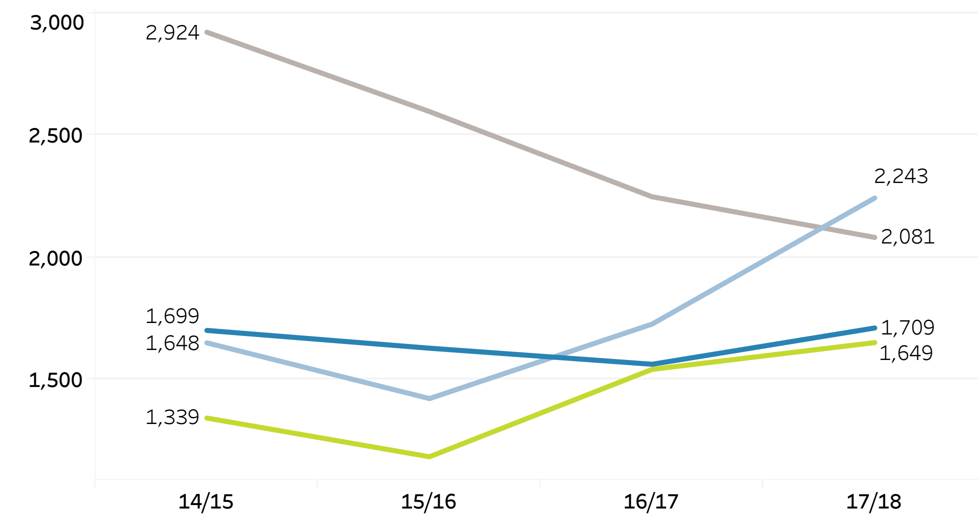
4. IMPACT: Percentage quitting at 4 weeks





The proportion of smokers who successfully quit at 4 weeks remains a challenge locally. There is some evidence that providers are not reporting timely data and this has an impact on recorded quits. Work is underway to improve this. It is also possible that as smoking prevalence declines the remaining smoking population are longer-term smokers, a more challenging cohort for traditional cessation services. If so, we may need to think about how additional support, possibly from LiveWell Dorset, could further strengthen quit attempts.

5. IMPACT: Number quitting at 4 weeks per 100k smokers



Despite lower than average success rates, overall we are delivering an increased number of successful quitters in recent years – due largely to good access and uptake. This contrasts with the national trends of falling numbers of successful quitters.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: PHE Fingertips

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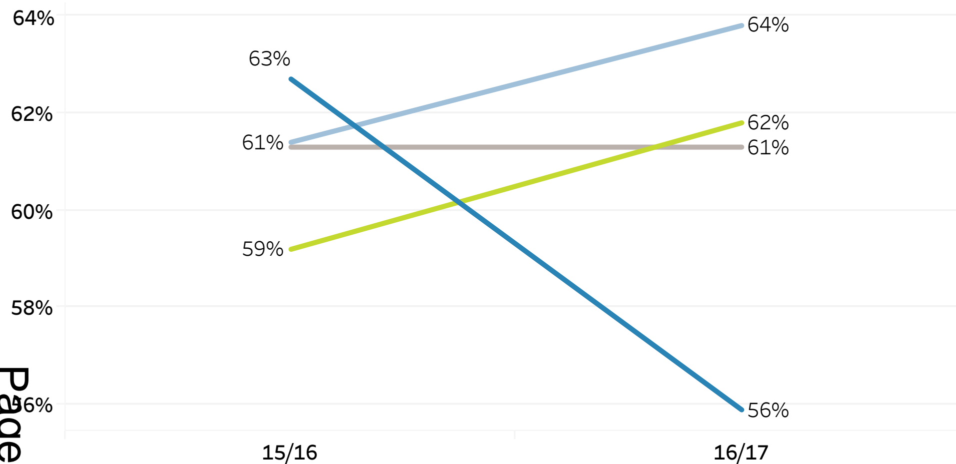
working together to improve and protect health

JOINT PUBLIC HEALTH BOARD WEIGHT MANAGEMENT PERFORMANCE REPORT

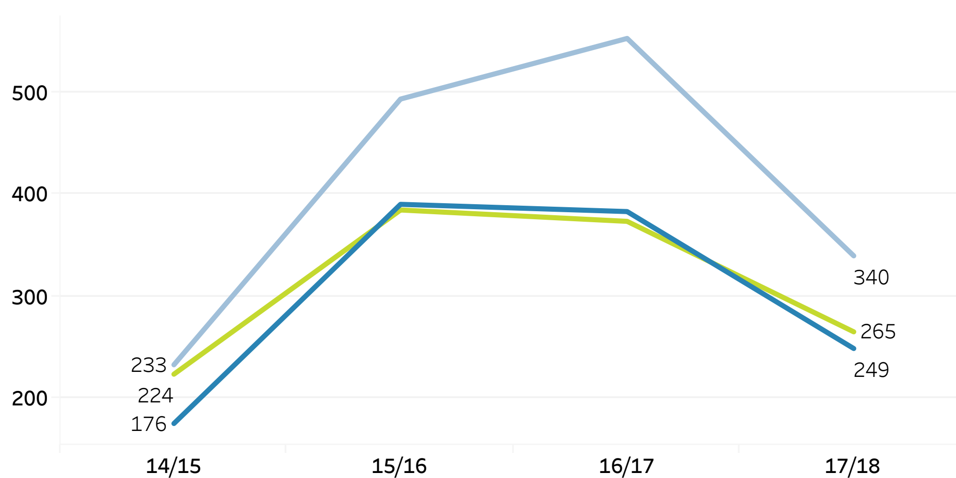
Area Name
- Bournemouth
- Dorset
- Poole
- England

1. PREVALENCE: Percentage of adults overweight or obese



The percentage of overweight and obese adults continues to gradually increase. Locally our pattern mirrors the national trend with Bournemouth as the exception.

2. SCALE: Number adults accessing weight management services per 100k pop



Take-up of weight management services has fallen back slightly in 17/18 compared to previous years. This reflects the dip in people coming through LiveWell Dorset in the second half of 17/18 towards the end of the contract with Optum, though numbers have now picked up again in 18/19.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: PHE Fingertips

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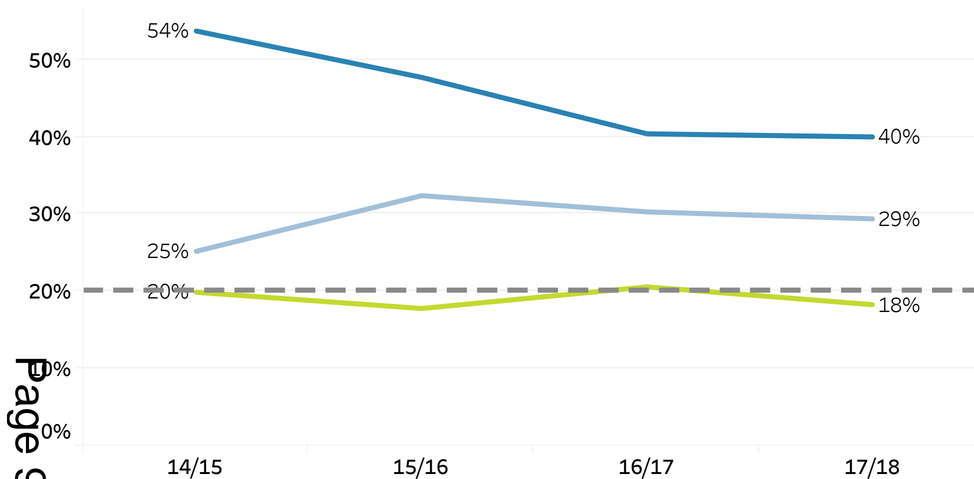
JOINT PUBLIC HEALTH BOARD WEIGHT MANAGEMENT PERFORMANCE REPORT

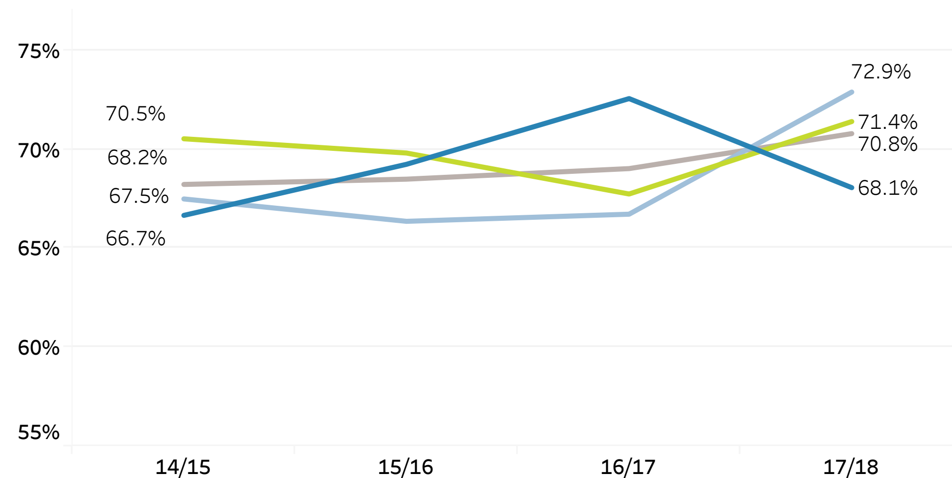
3. REACH: Percentage receiving a weight management service living in most deprived quintile



Local weight management services are engaging a disproportionately high number of people from communities with the highest levels of deprivation.

Area Name
- Bournemouth
- Dorset
- Poole
- Average

4. IMPACT: Percentage achieving target 5% weight loss



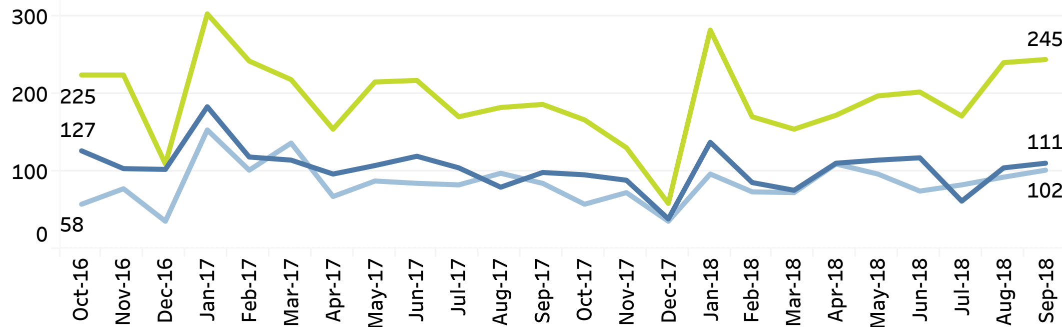
Though there is no national benchmark data available, we are assured by the weight management providers that the local performance is among the highest performers nationally.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: PHE Fingertips

Bournemouth, Poole and Dorset councils working together to improve and protect health

JOINT PUBLIC HEALTH BOARD LIVEWELL DORSET PERFORMANCE REPORT

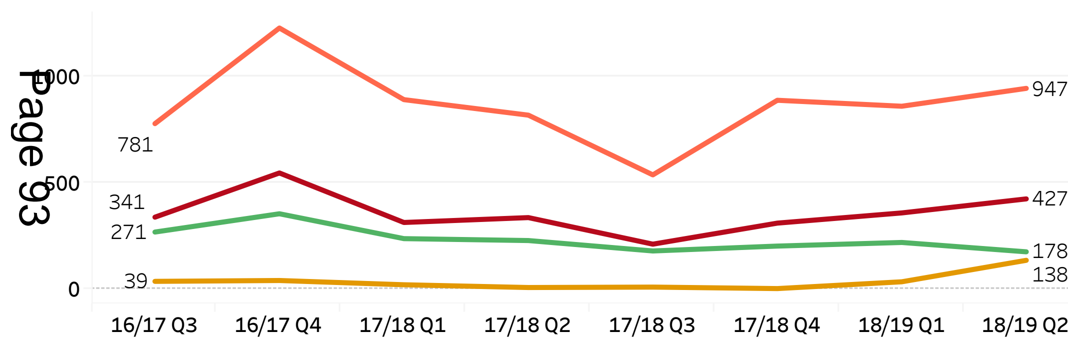
1. SCALE: Number of persons starting a service with LWD



Area Name
- Bournemouth
- Dorset
- Poole

LiveWell Dorset recently passed the milestone of having delivered support to over 20,000 local residents. This graph shows the general seasonal trend in accessing the service – with a clear peak in activity in January. Activity dipped slightly in the last 6 months of 17/18, towards the end of the contract with Optum, but activity has been high in the most recent few months of 18/19 following the launch of a range of new digital service offers.

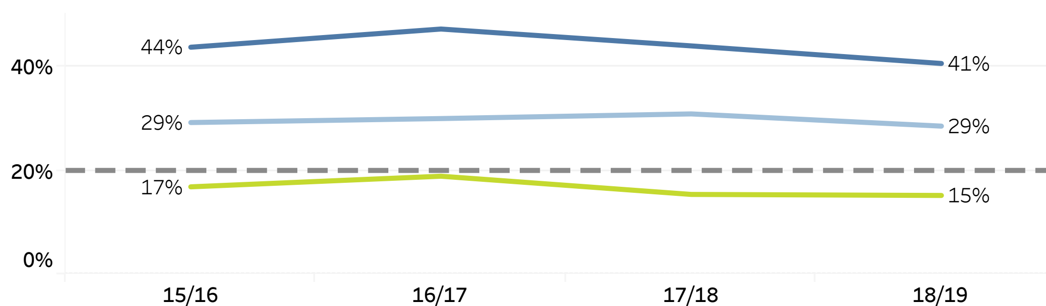
2. SCALE: Persons starting a service with LWD by pathway



Pathway
- Activity
- Alcohol
- Smoking
- Weight

Weight continues to be the most common pathway, in line with the prevalence of need in the population. The physical activity pathway has seen an increase in recent months following a performance management focus. The alcohol pathway has increased in the last 3 months, again – following a specific performance focus – but it is generally the least activated pathway as there are a range of alternative specialist commissioned services providing support. The cause in the recent downturn in smoking is unknown but will be investigated.

3. REACH: Percentage persons starting with LWD living in most deprived quintile



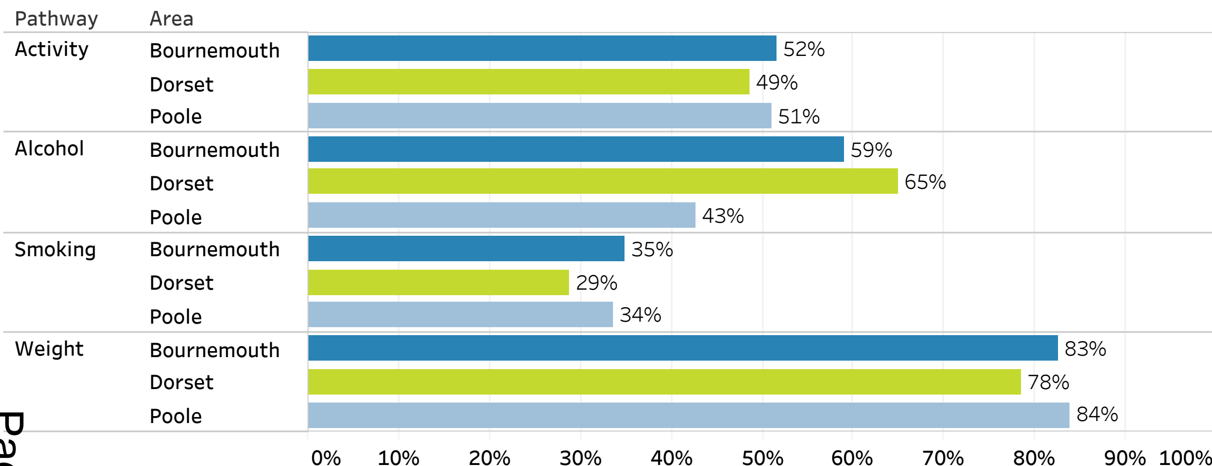
LiveWell remains effective in engaging individuals from the most deprived quintile. Overall the service engages 26% from deprived communities though this is considerably higher in Bournemouth, and to a lesser extent Poole, than in Dorset. Much of the variation is explained by the differential distribution of deprived communities across the pan-Dorset area.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: LiveWell Dorset

Bournemouth, Poole and Dorset councils working together to improve and protect health

JOINT PUBLIC HEALTH BOARD LIVEWELL DORSET PERFORMANCE REPORT

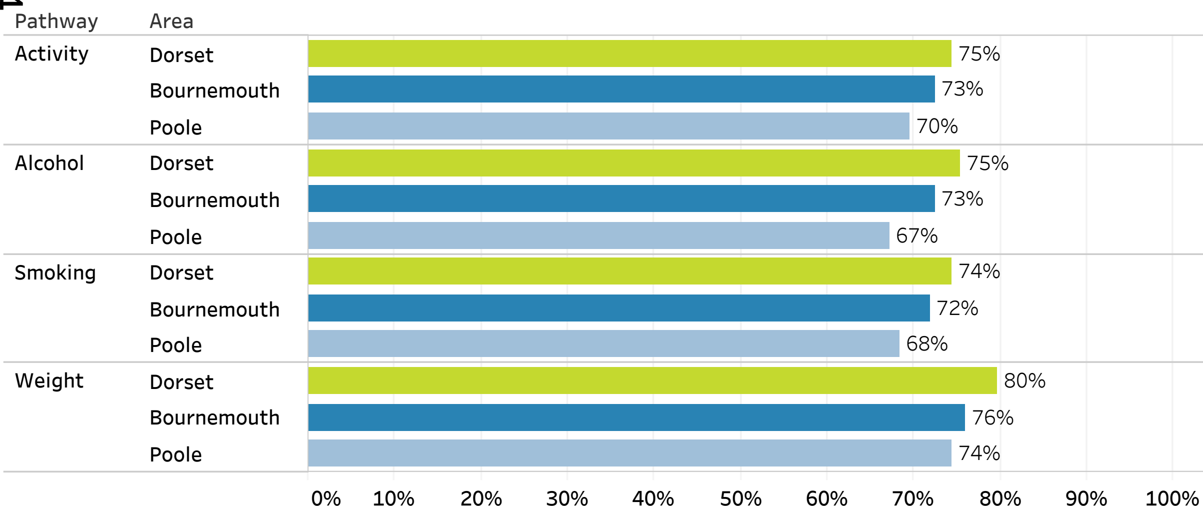
4. IMPACT: Pathways activated following a positive assessment of need 2018/19



Area Name
- Bournemouth
- Dorset
- Poole

The graph provides an indication of how effective LiveWell Dorset is at engaging people who have identified risk behaviours, regardless of what brought them to the service. For example, over 80% of people identified with a BMI of 30+ go on to activate a weight management pathway, yet only a third of people identified as smoking choose to take up a smoking cessation pathway. The findings are generally consistent across each local authority area.

5. IMPACT: Positive change reported at 3 months 18/19



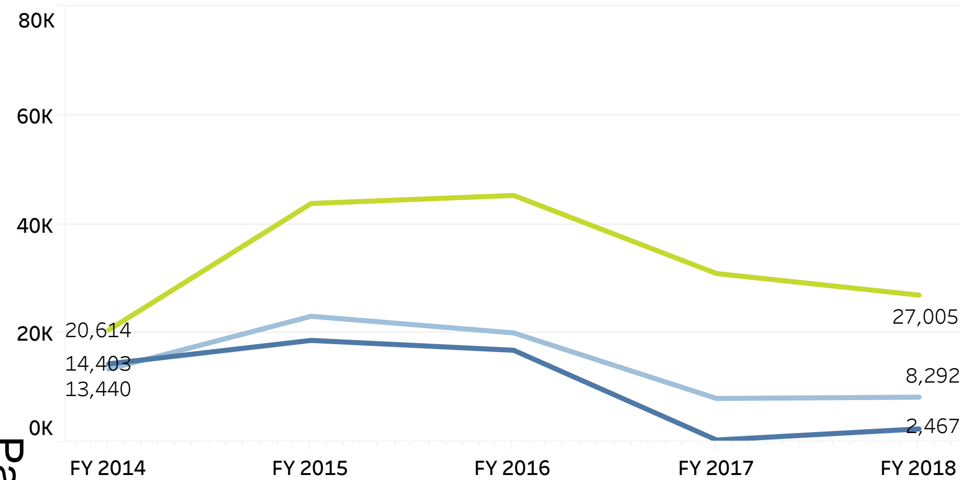
We have relatively robust data on outcomes of individuals at 3 months but more needs to be done to improve data capture at 6 and 12 months. Outcome data by pathway and local authority areas is generally consistent with around 75% reported positive change at 3 months. Change is defined as 5% weight loss, reduction in weekly alcohol units, increase in physical activity, and cessation of smoking.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: LiveWell Dorset

Bournemouth, Poole and Dorset councils working together to improve and protect health

JOINT PUBLIC HEALTH BOARD HEALTHCHECKS PERFORMANCE REPORT

1. Number of Healthchecks by local authority

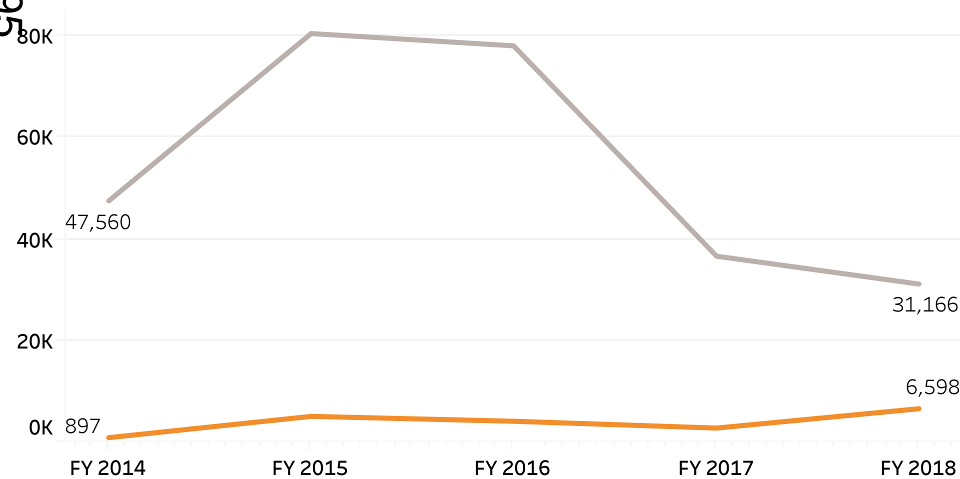


Area Name
Bournemouth
Dorset
Poole

Since the start of the NHS health checks programme, annual delivery of health checks has reduced in Dorset, Bournemouth and Poole and is significantly lower than national requirements. Health checks increased initially which peaked during 2016 and has since fallen.

A five year cumulative figure shows that overall in Dorset 50.5% of the population have been offered a health check and of those 25.5% have taken up the check. In Poole 44.3% of the population have been offered a health check and of those 23% have taken up the check. In Bournemouth 33% of the population have been offered and of those 15% have taken up the check. This is compared to national figures where 76% of the population have been offered a check and of those 48% have taken up the check.

2. Number of Healthchecks by location



Place
GP
Pharmacist

When looking at provider by location, health checks have remained higher with GP provider delivery, pharmacy delivery has remained lower. A reduction in delivery from the 2016 peak was due to service recommissioning, training and mobilisation issues along with difficulty in accessing the eligible population

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: PHE Fingertips

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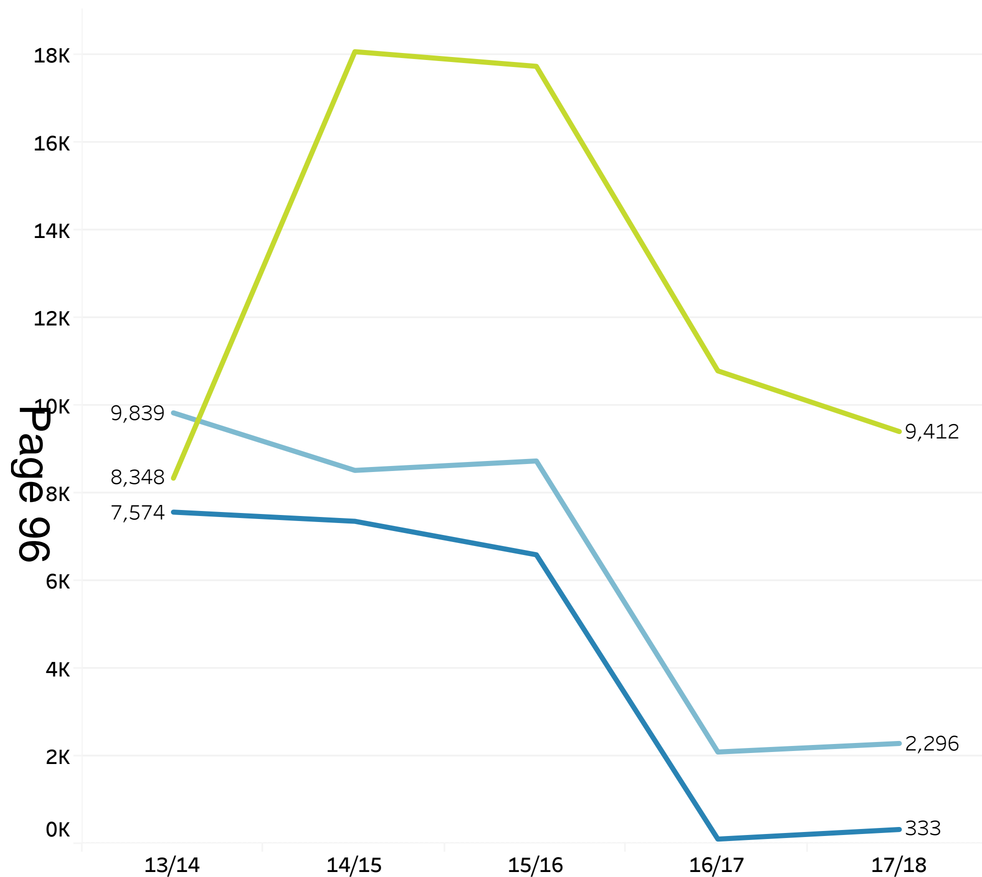
JOINT PUBLIC HEALTH BOARD HEALTHCHECKS PERFORMANCE REPORT

3. Number of Healthchecks Invites by Local Authority



Area Name
- Bournemouth
- Dorset
- Poole

When looking at Health check invites by locality invites are higher in Dorset compared to Bournemouth and Poole. In total during 2013/14 just under 25,500 invites were sent out to the eligible population compared to just under 33,000 in 2015/16 and just over 12,000 in 2017/18.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: PHE Fingertips

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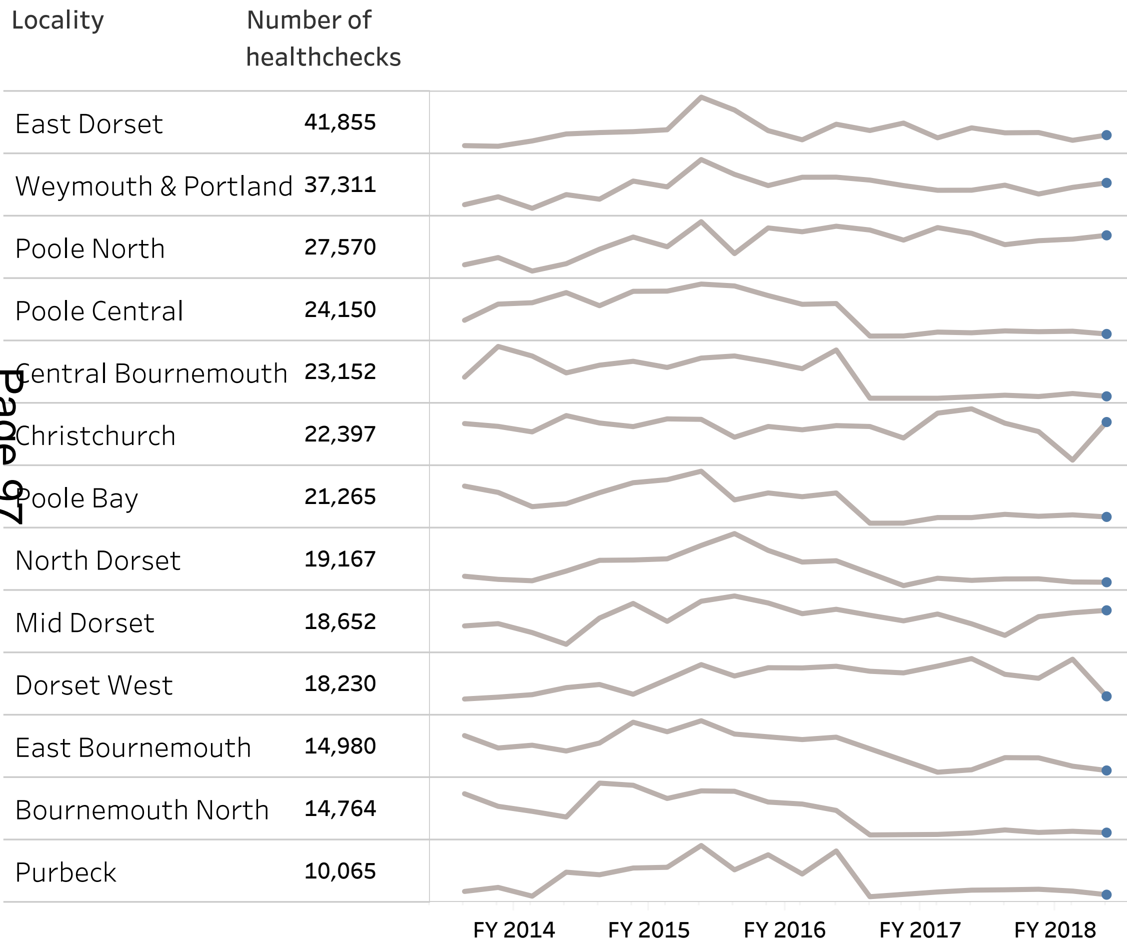
JOINT PUBLIC HEALTH BOARD HEALTHCHECKS PERFORMANCE REPORT

4. Number of Healthchecks by Locality



Locality	Number of healthchecks
East Dorset	41,855
Weymouth & Portland	37,311
Poole North	27,570
Poole Central	24,150
Central Bournemouth	23,152
Christchurch	22,397
Poole Bay	21,265
North Dorset	19,167
Mid Dorset	18,652
Dorset West	18,230
East Bournemouth	14,980
Bournemouth North	14,764
Purbeck	10,065

When looking at health check delivery by locality, checks are higher in East Dorset, Poole North and Weymouth and Portland and lower in North Dorset, East and North Bournemouth and Purbeck.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: Public Health Dorset

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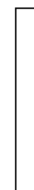
Joint Public Health Board



Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	19 November 2018
Officer	Chief Financial Officer and Acting Director of Public Health
Subject of Report	**Financial Report**
Executive Summary	The revised revenue budget for Public Health Dorset in 2018/19 is £28.292M, based on an indicative Grant Allocation of £33.407M. The report includes an updated forecast for 2018/19. Budgets for 19/20 remain provisional, based on indicative figures published in 17/18 and taking account of future local authority changes.
Impact Assessment:	Equalities Impact Assessment: An equality impact assessment is carried out each year on the medium term financial strategy.
	Use of Evidence: This report has been compiled from the budget monitoring information provided within the Corporate Performance Monitoring Information (CPMI).
	Budget: The Public Health Dorset shared service budget is currently forecast to underspend by £160k.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: MEDIUM Residual Risk LOW As in all authorities, financial performance continues to be monitored against a backdrop of reducing funding and continuing austerity. Failure to manage within the current year's budget not

	only impacts on reserves and general balances of the three local authorities but also has knock-on effects for the Medium Term Financial Plan and puts future service provision at risk.
	Other Implications: As noted in the report
Recommendation	The Joint Board is asked to consider the information in this report and to: 1. Note the updated 18/19 forecast; 2. Ongoing discussion in preparation for 19/20.
Reason for Recommendation	Close monitoring of the budget position is an essential requirement to ensure that money and resources are used efficiently and effectively.
Appendices	Appendix 1: Public Health Grant Allocations, Partner Contributions and Forecast: revised 2018/19, provisional 19/20.
Background Papers	Previous finance reports to Board
Report Originator and Contact	Name: Steve Hedges, Group Finance Manager Tel: 01305-221777 Email: s.hedges@dorsetcc.gov.uk

1. Background

1.1 The Health and Social Care Act 2012 established new statutory arrangements for Public Health which came into effect on April 2013. Significant responsibilities for public health were transferred to local councils from the NHS, and locally these are delivered through Public Health Dorset, a shared service across the 3 local authorities, funded through the ring-fenced Public Health grant. Public Health England was established and is responsible for public health nationally, and NHS England and Clinical Commissioning Groups also have some continuing responsibilities for public health functions.

1.2 Since 2013 there has been a further national transfer of responsibility for Health Visiting services, which moved to local authorities in October 2015; the local agreement was that this was commissioned by Public Health Dorset. Public Health Dorset have also taken on additional responsibilities for commissioning drug and alcohol services from each local authority in 2015 and again in 2017.

1.3 Public Health Dorset have made significant returns to the 3 local authorities in line with principles previously agreed at the Board. These returns are also subject to the ring-fence grant conditions.

1.4 Alongside the publication of the final allocations for 2018/19, PHE published indicative allocations for 19/20 and announced that the Public Health Grant ring-fence and grant conditions will remain in place until at least 31 March 2020. No further formal communication has been made since then.

1.5 PHE have investigated issues with a number of councils nationally about how the ring-fenced grant is used. For example, Northamptonshire council was directed to reinvest £8M in public health services earlier this year after PHE determined that funds were used to prop up adult and child social care programmes rather than in line with the grant conditions.

2. Budget and Forecast Position 2018/19

2.1 The opening revenue budget for Public Health Dorset in 2018/19 was £28,592k. This was based on a Grant Allocation of £33,407k, a 2.5% reduction over the grant allocation for 2017/18, and a further shift in responsibilities for drug and alcohol services reflected in retained PTB and DAAT elements.

2.2 The revised budget is now £28,292k. This takes account of:

- the return to councils of anticipated £450k underspend as highlighted at the last Board; and
- transfer of £150k transformation funds from Dorset CCG to support PAS.

2.3 Detail of the Public Health Grant Allocations and partner contributions is in Appendix 1.

2.4 The current forecast for 2018/19 is for an underspend of £160k (see appendix 1). This takes account of:

- Updated estimates for cost and volume activity, although detox and Health Checks could still see significant change by year end.

2.5 As the LiveWell Dorset service becomes more embedded across the system, there are knock-on impacts for our other health improvement services. This has been to some extent anticipated, but remains under close review.

3. Provisional Budget 2019/20

3.1 Indicative allocations for 19/20 based on current local authorities were published in 17/18, and a provisional Public Health Dorset budget, adjusting on a population basis for the new footprints, was shared at the last Board (see appendix 1). Final grant figures based on the new footprint have not yet been published.

3.2 Work continues with finance colleagues across Dorset, Bournemouth, Poole and Christchurch to understand the implications for the new footprints, both on the shared service budget and the Medium Term Financial Plans for the two new authorities.

4. Conclusion

4.1 The Joint Board is asked to consider the information in this report and to note:

- the updated 18/19 forecast;
- ongoing discussion in preparation for 2019/20.

Richard Bates
Chief Financial Officer

Sam Crowe
Acting Director of Public Health

November 2018

APPENDIX 1: Public Health Grant Allocations, Partner Contributions and Forecast: revised 2018/19, provisional 19/20.

Table 1: Revised budget 2018/19, provisional budget 19/20

2018/19	Poole	Bmth	Dorset	Total
	£	£	£	£
2018/19 Grant Allocation	7,594,000	10,502,000	15,311,000	33,407,000
Less Commissioning Costs	-30,000	-30,000	-30,000	-90,000
Less Pooled Treatment Budget and DAAT Team costs	-461,000	-2,924,800	-170,000	-3,555,800
2014/15 Public Health Increase back to Councils	-299,000	-371,000	-499,100	-1,169,100
To redistribution of anticipated 18/19 underspend to B/P/D for reinvestment (See 2.2)	-90,000	-112,500	-247,500	-450,000
Joint Service Budget Partner Contributions	**6,714,000**	**7,063,700**	**14,364,400**	**28,142,090**
Budget 2018/19				**28,142,090**

Provisional 2019/20	Bmth, Poole & Christchurch	Dorset	Total
	£	£	£
Estimated 2019/20 Grant Allocation	18,533,290	13,991,710	32,525,000
Less Commissioning Costs	-60,000	-30,000	-90,000
Less Pooled Treatment Budget and DAAT Team costs	-3,385,800	-170,000	-3,555,800
2014/15 Public Health Increase back to Councils	-670,000	-499,100	-1,169,100
Joint Service Budget Partner Contributions	**14,417,490**	**13,292,610**	**27,710,100**
Provisional Budget 2019/20			**27,710,100**

Shift based on population as per disaggregation workstream

Table 2: Updated forecast 2018/19

2018/19	Budget 2018-2019	Outturn 2018-2019	Over/underspend 2018/19	Provisional budget 2019/20
Public Health Function				
Clinical Treatment Services	£11,531,000	£11,567,268	-£36,268	£11,371,500
Early Intervention 0-19	£11,104,000	£11,114,620	-£10,620	£11,104,000
Health Improvement	£2,342,200	£2,111,042	£231,158	£2,475,000
Health Protection	£85,000	£26,022	£58,978	£73,100
Public Health Intelligence	£207,800	£146,164	£61,636	£197,800
Resilience and Inequalities	£610,790	£878,481	-£267,691	£187,000
Public Health Team	£2,411,300	£2,288,004	£123,296	£2,301,700
Total	**£28,292,090**	**£28,131,601**	**£160,490**	**£27,710,100**

Resilience and inequalities budget increased by £150k, Dorset CCG funding for PAS

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